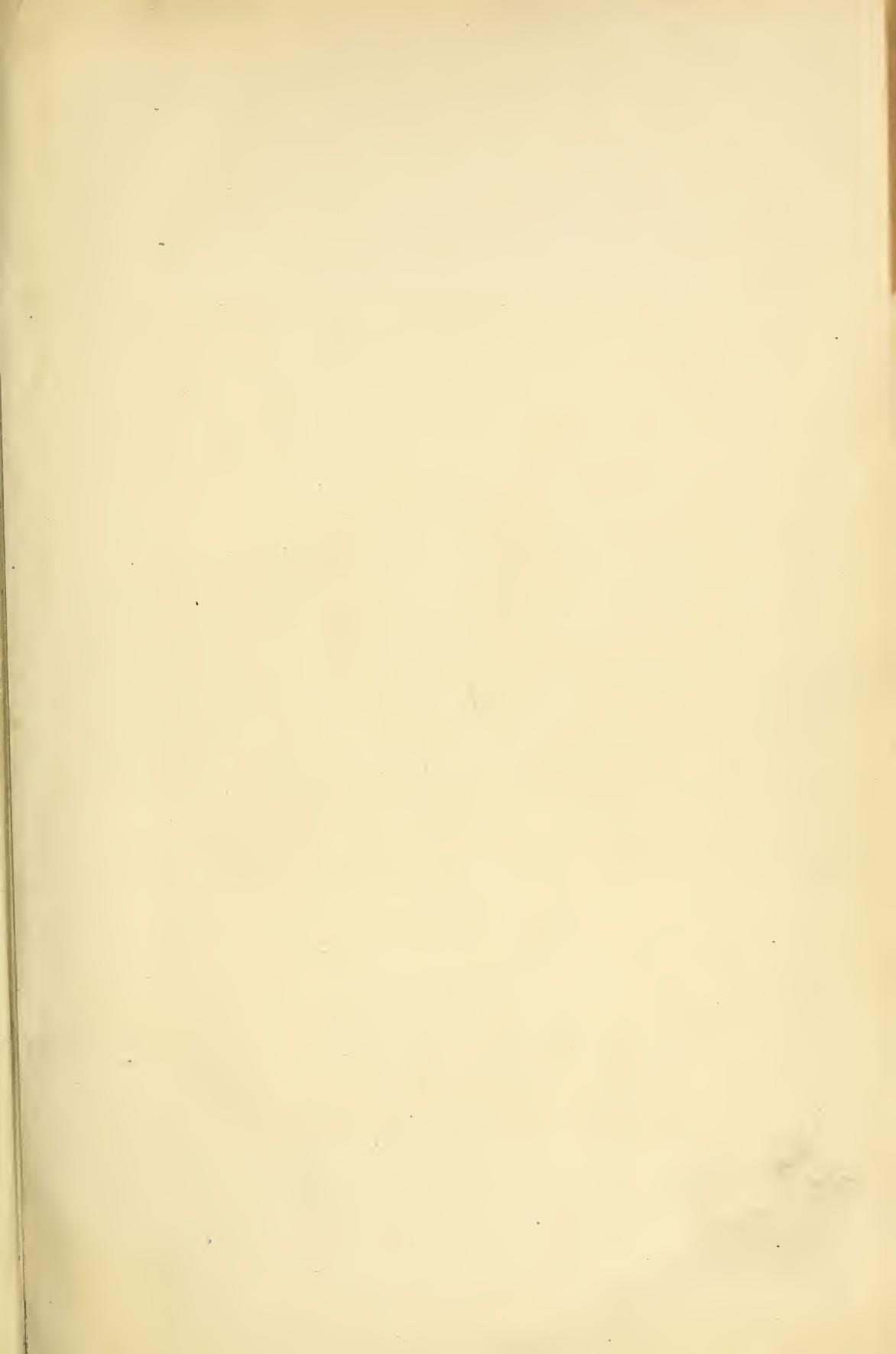






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MARYLAND
MEDICAL JOURNAL.
A WEEKLY JOURNAL OF
MEDICINE AND SURGERY.

VOLUME XXIII.

MAY, 1890.—OCTOBER, 1890.

WILLIAM B. CANFIELD, A. M., M. D.,
Editor.

—PROPRIETORS—
JOURNAL PUBLISHING COMPANY.

BALTIMORE:
JOURNAL PUBLISHING COMPANY, PRINT,
209 Park Avenue.
1890.

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MARYLAND MEDICAL JOURNAL,

VOL. XXIII. No. 1. BALTIMORE, MAY 3, 1890.

NO. 475.

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THE MODERN HOSPITAL.*

BY A. FRIEDENWALD, M. D.
OF BALTIMORE.

I have selected for the subject of the address which I have the honor to deliver on this occasion "The Modern Hospital." It has suggested itself to me in contemplating the significance of the two new hospitals which have been established in this city since last we met.

The Johns Hopkins Hospital, which had been in process of construction quite a number of years, and whose completion the profession and the public were anxiously looking forward to, was opened on the seventh day of May, 1889, and has since then been in successful operation. The new City Hospital, occupying the site of the City Spring, on Calvert street, was formally opened on the 23rd

day of December, 1889. The acquisition of these two hospitals has marked a great advance in the history of Baltimore in regard to its humane institutions. The work that has been done by them has amply demonstrated how greatly they were needed. The former, the consummation of a most munificent foundation, has shown to what successful results large sums may be devoted in the study of the most approved plans in hospital construction, while the latter, called into being by a religious order, beginning its work without any means, has taught how much can be accomplished with a comparatively moderate amount of money by a judicious and economical plan of building. Both institutions have taught most valuable lessons, which will surely be utilized in the building of hospitals hereafter in our city (for it is safe to predict that it will not be so very long before others will be needed), as well as in others that will be erected elsewhere. With the progress in the science of hospital construction, the methods will

*President's Address at the 92nd Annual Meeting of the Medical and Chirurgical Faculty of Maryland, April 22nd, 1890.

undoubtedly become more and more simplified. Much has already been accomplished in this respect, and no small amount has been contributed by the experience in military hospitals in our own country during the civil war.

In speaking of the "Modern Hospital" we must have before our mind's eye the hospitals in our time which have fulfilled or which will fulfill the full demands of the most advanced knowledge of hygiene, and which will at the same time exhibit a simplicity of construction which will enable them to be administered on an economical basis. Furthermore, it should be fully expected that the best medical attention should be furnished to those suffering from disease and seeking relief within their walls. Important as the conditions just referred to are to the modern hospital, an efficient humane nursing is being more and more looked to as a factor in the successful management of these institutions. And lastly, the patient who enters such a hospital should be spared the mortification of possibly being looked upon as a common pauper, when his needy condition is due to his illness alone. In a word, the modern hospital should offer bountifully all that is made possible by an advanced science and by a refined humanity.

The hospital has a much older history than it is commonly credited with. When we consult this history we learn that it has not emanated from any single civilization. In times remote and in lands far distant from each other, when, as is generally supposed, barbarism had considerable supremacy, the hospital was not unknown. The civilization which has done most to develop the hospital, to perfect its methods and to extend its usefulness, cannot claim to have originated it. While it must be accorded to Christianity that the hospitals as they existed through these many centuries owed their existence to its influences, it is but due to recognize that in still earlier times there were peoples differing greatly from each other in faith, not knowing each other, who saw the helplessness of

the sick, felt for them and provided places in which they could be cared for.

In a book, the *Mahawanso*, edited by Gerge Turnour (Ceylon, 1837, Vol. I, pp. 66 to 196), we find recorded that King Pandukabhayo, who reigned in Ceylon, 437, B. C., founded a hospital in his capital city, Anaradhapura, beside other sanitary establishments. His successor, Dutthagamini, who died 137 B. C., had a list of his benevolent acts read at his death, in which there is enumerated, "I have constantly maintained hospitals at eighteen different places, and supplied medicines through medical practitioners."

The Hindoos provided hospitals not only for man, but also for animals.*

In a collection of heroic poems, "*Shah Nameh*," on the ancient histories of Persia, it is stated that from the earliest times the fire-worshippers were obliged, in accordance with their laws, to supply suitable establishments for their indigent sick, and that the king was in duty bound to provide gratuitously the best medical treatment for the inmates†.

The origin of the hospital has been traced as far back as the temples of Aesculapius, at Titanus, 1134, B. C. In alluding to this, Dr. John Watson, in his "*Anniversary Discourse before the New York Academy of Medicine*," says, "As asylums, these temples bore no inapt resemblance to the hospitals and infirmaries of modern times, into which some of them were ultimately converted. The temples of Aesculapius, Cos and Tricca, according to Strabo, were always filled with patients, and along their walls were suspended the tablets upon which were recorded the history and treatment of the individual cases of diseases."

The oldest Buddhist accounts of hospitals in the inscriptions of Piyadasis or Acokas reach to the middle of the third Century, B. C. According to Virchow, it is probable that the first larger Christian hospitals which developed in Asia

*Alexander Burns; *Journ. of the Royal Asiatic Soc* 1834, No. 1, p. 96.

†Hospitals Boylston Prize Essay of Harvard University, 1876, by W. Gill Wyllie, M. D.

Minor and Persia, owed their origin somewhat to Buddhist influence, for Buddhism pushed forward to the West at an early date and at the beginning of the Christian era, had already reached Kabul and Bacterien.[‡] The edicts of Buddhism in regard to hospitals were cut upon rocks during the reign of Asoko, who died 226 years, B. C. One of these, bearing the date of 220, B. C., can be read to-day. It enjoins that hospitals shall be established on the highways of travel, and that they shall be provided with medicines and instruments and skillful physicians at the expense of the state.[§]

The Spaniards found, on their arrival in Mexico, that the Aztec civilization had amply provided for the treatment of the sick and for the care of disabled soldiers in hospitals in their principal cities.^{||}

According to these data, we are forced to conclude that the hospital had been regarded as a public necessity, that human suffering had received that warm sympathy which provided means for its relief among many nations, long before the time we were wont to believe that the hospital had had its beginning.

It is quite probable that the methods of these ancient institutions were so crude that although inaugurated by the holiest sentiments they did as much harm as good. We are to some extent warranted in assuming this when we contemplate the fearful mortality which stands against the account of hospitals of even a much later date. The hospitals in Europe had a most varied development. We have found that the hospitals of the Hindoos and Persians had their origin in religion, so did these owe their existence to the Church.

In the early centuries Pilgrims began to direct their way toward Jerusalem. About the middle of the seventh century, near the time that the Orient inaugurated its pilgrimage to Mecca and Me-

dina, thousands] undertook pious journeys from France, England and Germany to Rome. On all the roads leading to that city, provision was made to extend shelter and food to these wayworn travelers. At every monastery, near many mountain passes and in the vicinity of the larger bridges crossing impassable streams, houses were erected in which these strangers were hospitably received. These houses were under the management of religious orders. They were too limited in their capacity to offer any prolonged residence to those who sought their shelter, and were, therefore, not intended for the sick and in exceptional cases only did these obtain admission. It is fair to assume however, that they had much to do in offering the incentive to the erection of hospitals in later times.

But long before this period hospitals had been established. They were spoken of ‘in the Council of Nice, A. D. 325, as institutions well known and deserving support and encouragement.’^{**} Although we find no mention of any special hospital existing at this time in Europe, the language quoted above is conclusive in this regard. The Hôtel Dieu in Lyons was established in 542 by Childebert I., at the instance of the Archbishop of Sacerdos.[†] This hospital was also termed Xenodochium, and was under the supervision of laymen, but was transferred to the care of the clergy six hundred years afterward:

The rage of leprosy, which continued up to the fifteenth century, must be regarded as a most potent factor in promoting the growth of hospitals. The condition of its unfortunate victims was most pitiable. Not only did they suffer from the effects of a disease the most dreaded of all of that time, but besides the cruelties inflicted upon them by the disease itself, they had to submit to cruelties from their fellowmen. The diseased were removed from the home of man, excluded from religious assemblies,

[‡]R. Virchow, *Ueber Hospitaeler und Lazarette*, Berlin, 1869.

[§]Hospitals; by W. Gill Wylie, M. D.

Prescott, *Conquest of Mexico*, Vol. I, p. 48.

^{**}Dr. Toner's Contributions to the Annals of Progress in Medicine.

[†]C. F. Heusinger. Ein Beitrag zur altesten Geschichte der Krankenhäuser im Occidente,

and completely ostracized in every way. But finally there was mercy in store for them too. Men imbued with religious spirit began to care for the unfortunate ones. Prominent among these was the Bishop of Cæsarea, who built a town of small homes before the gates of the city for the reception and care of the sick of all kinds not excluding those suffering with leprosy. These establishments warmed up the spirit of benevolence which led to the organization of similar institutions all over Christendom till these were counted by thousands. They had been instituted in large numbers in the south and west of Germany in the seventh and eighth centuries. At an early date, possibly even before the crusades an order of knights was organized originally consisting exclusively of lepers the Knights of St. Lazare, whose object it was to care for lepers and subdue the unbelievers. Called to Europe by Louis VII. of France in 1149 the order established a large number of leper-houses which subsequently became known as Lazarettos. The order reached Germany by way of Hungary. Eventually, this order did not escape proscription and could only maintain a foothold for itself in Savoy. It still continues here, enjoying the highest esteem and still charging itself with the care of lepers.‡ When the scourge had neary reached its extinction in the middle of the 16th century, the leper-houses lost their significance. Many were converted into institutions for the care of the aged and infirm, and a few continued as hospitals. The term Lazarettos was subsequently often employed to designate hospitals devoted to the care of those suffering from contagious diseases.

During this time there were but few cities of importance in Europe that had not a hospital of some kind. A great many of them have been forgotten. They had but a local interest, often ended their careers and left no record for future times.

‡Cibrario; *Précis Historique des Ordres Religieux et Militaires de St. Lazare, et de St. Maurice avant et après leur Reunion.* Lyon, 1860, Pp. 10

The Hôtel Dieu, of Paris, was founded about the year 600, somewhat more than half a century later than its namesake in Lyons. It is probably the oldest hospital in Europe now in use.

In England the first institution for the care of the sick was established by Lanfranc, Archbishop of Canterbury, in the year 1070.

In regard to the more important hospitals of Germany, Berlin seems to have acquired them before any other city, the Hospital of the Holy Ghost and St. George's Hospital having been erected in 1070 and 1208 respectively.

The famous hospital at Milan, with a capacity for over 2000 patients, was opened in 1456, and is still used for its original purpose, and is regarded as a remarkable building at the present time.

It is rather surprising, when we consider the fact that war had been almost incessant, to find no account of provision being made for military hospitals prior to nearly the close of the sixteenth century. A hospital established through the influence of Ambrose Paré, at the siege of Metz, in 1575, seems to have been the pioneer in this class of humane institutions.* Indeed, previous to the time of this great surgeon there seems to be no evidence that surgeons were considered necessary to military organization. An English author, describing the disregard of sick and wounded soldiers in the British army as late as the 16th century, states that "the poorer soldiers, when seriously wounded, were discharged with a small gratuity, to find their way home as best they might, a fact founded on the economical principle that it costs more to cure a soldier than to levy a new recruit."† In connection with the early development of hospitals, a brief allusion to what took place in America may not be uninteresting. Quebec is credited with having had the first hospital after this continent was settled by Europeans. It is said that a small hospital was established in that

*On the Establishment of Army Hospitals, by Edward A. Crane, M. D.

†Sir L. D. Scott's "British Army."

city as early as 1339.‡ In 1658 a hospital (consisting of five houses in 1679), was organized on Manhattan Island for the benefit of sick soldiers and for the West India Company's negroes.‡

Among the notable acts of Benjamin Franklin, it stands to his credit to have lent a helping hand to Dr. Thomas Bond, who originated the movement the outcome of which was the Pennsylvania Hospital. This hospital obtained its charter in 1751, used temporary buildings till 1759, and completed the present building in 1805. We may judge of its importance in early times by the fact that 435 patients were admitted into it in 1775. The New York Hospital was destroyed in 1775, when it had hardly been completed. It was first built mainly through the exertions of Dr. Samuel Bard and Dr. John Jones, professors in the medical school of King's College. It was rebuilt in 1791.

Hospitals have largely been found very deficient, both in their construction and in the mode of their administration regarding the sanitary requirements of the sick, hygiene being quite a new science.

It has been reserved for our time to give a more due consideration to guarding the sick against the danger which, in addition to their disease they may be exposed to be exposed to from these sources in the institution in which they seek relief. The conditions which created the demands for hospitals in their early development in Europe were of so urgent a nature and the distress of those seeking them was so great that any place seemed good enough for their reception.

Beside the humane spirit which provided the hospital for the benefit of the unfortunate ones, they served to no small extent the purpose of pest-houses, to which communities looked for safety from infection. These fears were very often well grounded, very often they rested on superstition alone. How much the sick would injure one another when crowded together in unsuitable buildings did not

apparently attract much attention. The old methods were not questioned at all for a very long time. At last, though, light began to break in in. Men began to enquire whether the fearful death-rate of these institutions was due to the character of the diseases which prevailed there and therefore unavoidable, or whether there was not something by which the sick were surrounded, which intensified their diseases and increased their dangers. Reference to a list of history in connection with the Hôtel Dieu, in Paris in the 18th century, will furnish an appalling account. The following spectacle is described as having been presented in that institution during this period. Two or three patients afflicted with small-pox, or several surgical cases, or four women in the parturient state were assigned to *one* bed. A large proportion of the beds were made at that time expressly to afford room for four patients, and sometimes as high a number as six were packed in one. In the Salle St. Charles and Salle St. Antoine there were 139 beds for four patients each (many of which contained six), and only 38 beds intended for one person each. The law forbade the hospital authorities to refuse admission to any one, without regard to the number that might already have been received. There is no account of such crowding together of the sick in England, but there was sufficient to have caused a disastrous amount of erysipelas, hospital gangrene and surgical fever, and puerperal fever, up to a very recent time. The same story would have to be told of the hospitals of Germany and of other countries.

Although warning voices were raised against this state of things about the middle of the 18th century and the great importance of allowing ample breathing-space and of providing for proper ventilation, had been advocated, it took a full century before these points received practical consideration in hospital construction. Bœrhaave taught, early in the 18th century and dwelt forcibly on the vitiation of the air in hospitals, where

‡J. W. Beekman, Centennial Address, N. Y. Hosp., 1871.

many patients were crowded together, and on the value of securing an ample supply of fresh air the sick and wounded.* Among his pupils there were four who did good service in suggesting improvements in the sanitary management of military hospitals; these were Sir John Pringle, Gerard van Swieten, Donald Munro and Richard Brocklesby.

Among the earliest writings on hospital reform we find the valuable contribution of Dr. John Jones, whose name has already been mentioned in connection with the origin of the New York Hospital. In a work published in 1775, entitled "*Plain, Concise, Practical Remarks on the Treatment of Wounds and Fractures,*" he added a short appendix on Camp and Military Hospitals. Dr. W. Gill Wylie, commenting on the advanced views presented in this book, says that "they ante-date by more than ten years any other publication we have been able to find." The terrible death-rate experienced by the French and British armies during the Crimean war was the impetus to secure the first great advance in the methods of constructing hospitals for the sick and wounded. Michael Levy, sanitary inspector of the French army in the Crimea, proposed, in 1854, simple wooden barracks raised from the ground and provided with ridge ventilation.† It was in the good work growing out of the experience of the Crimean war that the name of Florence Nightingale has been immortalized.

The valuable knowledge that was gained from the observations of that period was practically and most successfully applied in the grand hospital system that was organized during the late civil war. From this time onward it has been the constant concern of those connected with the management of hospitals everywhere to improve their construction and to get rid in every way of the dangers that have heretofore beset their inmates. Statistics have been studied carefully and quite

valuable conclusions have been reached. Sir James Simpson has shown that the deaths from amputation ranged from 36 to 47 per cent., while the same operations in country practice gave a death-rate of only 18 per cent.

	Deaths per 1,000.
St. Bartholomew's Hospital	366
London Hospital, Whitechapel	473
Guy's Hospital	382
St. Thomas' Hospital	388
Nine London hospitals	411
Royal Infirmary, Edinburgh	433
Royal Infirmary, Glasgow	391
Eleven large Metropolitan Hospitals	410

The statistics furnished from lying-in-hospitals show similar results. Dr. Lefoot collected statistics of 888,302 cases delivered in lying-in-asylums, and of 934,781 attended at home; the deductions from these are: that in hospitals, 35 per 1000 die, while at home there are only 4½ deaths to the 1000.

Baron Meydell, Chief of the Sanitary Department of St. Petersburg has found that in the larger lying-in-hospitals in which 2000 women are confined yearly, there is a death rate of 40 per cent. in those in which 1000 are delivered, only 25 in 1000 die; in institutions in which 400 are attended, not more than 20 in 1000 die, and in small hospitals having from 2 to 3 beds of which there are 11 in different parts of the city, giving accommodation to 1600 cases, only 9 in 1000 die, while those confined in their homes including the poorest and most wretched show a mortality of only 5 in 1000.§

The additional danger which surgical cases and women in the lying-in state encountered on entering a hospital was long recognized. There seemed to be no remedy for this, especially in the case of the poor who were driven by their need for help into these institutions. Hospitals were regarded in connection with these cases as necessary evils. As astute an observer and as high an authority as

*W. Gill Wylie, Hospitals; p. 22.

†Report of the Proceedings of the Sanitary Commission dispatched to the Seat of War in the East, 1855 and 1856.

§Report du Congrès International D'Hygiène et de Sauvage, Brussels, 1876. Vol. I, Pp. 226.

Virchow in everything that relates to medical science said—as late as 1861 : “We know that in many cases hospitals increase the danger of the condition of those consigned to their care, and it should be made the object of practical science to limit their uses as much as is possible ; especially in the treatment of the wounded and of those in the lying-in state” || The simple wooden barracks which were adopted as offering the best form for military hospitals, during the late civil war, demonstrated conclusively the great advantage of a plentiful supply of fresh air in the hospital ward. These buildings were so arranged that every individual ward was a building standing by itself, so that the light and the air could not be readily excluded. It was this experience which first put the pavilion system, that had already been adopted in Hôpital Lariboisière in Paris, to a most extensive test and from which it has grown more and more in favor. In the construction of hospitals to-day, whether the pavilion system is adhered to or not, the primary precaution for the benefit of the sick, satisfactory ventilation and perfect drainage are not likely to be neglected. Any direction in this regard, in the light of our present knowledge cannot be regarded but as culpable. Much, however, as may be justly claimed for the introduction of scientific ventilation in the modern hospital, it is principally through antisepsis that the advanced character of the modern hospital has been attained. It is not long since the surgeon before performing an operation or assuming charge of the wounded, was more or less haunted by the additional danger the patient incurred on entering a hospital, which was ascribable to the direct hospital influences, and not seldom would he persuade the patient to be treated in a more favorable environment. Antisepsis has changed this radically and now the hospital is regarded as the safest place where the more important surgical cases can be

cared for. In regard to the treatment of lying-in-women, antisepsis has proved an equal, if not a still greater blessing. Puerperal fever, which was the terror of the institutions into which these patients were received, and to check the spread of which our art had proved utterly powerless, is fast vanishing, and from all recent appearances will occur much more seldom in these institutions than in private practice. The statistics of the Vienna Lying-in Department will fully justify this assertion. During the year 1823 there was a mortality of $7\frac{1}{2}$ per cent., which gradually rose till it reached a death-rate of 15 per cent. : in 1842 every 6th or 7th case in this department died of puerperal fever. The reform which Semmelweis suggested was introduced in 1847, and the mortality was reduced to 1.3 per cent. Under the precautions enforced by recent methods of antisepsis, the rate of mortality fell to $\frac{3}{4}$ per cent. in 1882, and since this time it has been claimed that the disease has almost entirely disappeared. In the new hospital of Prague the death-rate has been reduced to less than $\frac{1}{4}$ per cent.

The hospital of to-day, under these changed circumstances, makes quite a different impression upon the general public than in former days, when it partook more or less, whether it continued to bear the name, or not, of the character of the Lazaretto. Heretofore, it was to a great extent made use of only by those, who either having no homes of their own, or being destitute of the means which might have secured for them the proper treatment elsewhere, had no choice left. It is now pretty well known that there are many conditions in which a patient can be better provided for in a hospital than in his own home. Persons in moderate circumstances would often be prevented, in cases requiring special skill, of obtaining the best treatment, unless they could enter a properly equipped hospital, either at a small cost or gratuitously. The humane character of the hospital has been greatly enlarged, for it is not now restricted in its beneficence to those in abject poverty.

||*Über den Fortschritt in der Entwicklung der Humaenitätsanstalten. Versammlung Deutscher Naturforschers and Aerzte. 1861. XXXV.*

There is one important factor entering into the combination which makes up the character of the modern hospital, which is asserting itself more and more every day. The very best administration, the most faithful and skilled medical staff, can provide but for a part of the requirements of such an institution. The patient needs, beside all that these can offer—the services of a kind, an efficient, an intelligent, a faithful, nurse. To be qualified for such a service demands, primarily, a devotion to the calling. No other motive would be strong enough to yield the self-sacrifice which its duties exact. Religious orders have long provided for this want. The noble work which the good women have accomplished, who, having renounced the pleasures of this world under religious vows to devote their lives to the service of the sick, embraces a record of heroism which at once challenges our admiration and our gratitude. The good Sisters who have been the pioneers in this humane work will certainly not be the last to accept the improved methods which a new experience may develop in the service to which they have consecrated their lives. In recent years a class of refined and intelligent women not bound by vows, but inspired by the most humane sentiment, have entered into the service of the sick. Schools have been established in connection with hospitals, which have afforded them the means of acquiring the theoretical knowledge and the practical experience necessary for such a vocation. This has at once proved a new blessing in the service of the modern hospital, and given dignity to a calling which too often has been regarded as of a servile character. We may now begin to hope that the day is past when the kind offices to the sick will be entrusted to the ignorant or unfeeling nurse who has no interest in the work, but the wages that it brings; or to the convalescent, who is expected to render some service for the benefit which he has received. It is highly gratifying to notice the increasing liberal and humane spirit that both our city and our

State have lately manifested in the conception of their duty towards the indigent sick. There was a time when the consciences of the authorities were fully satisfied with the service that was done for them in the city and county almshouses, far as these fall short of hospital requirements. It has at last been acknowledged in a substantial manner by the appropriations that have been made, that the city and the State have a duty towards those who need help, but do not deserve to be placed on a level with the common pauper.

INFLAMMATION OF THE VERMI- FORM APPENDIX; ITS RESULTS, DIAGNOSIS AND TREATMENT.*

TOGETHER WITH THE REPORTS OF SEVEN
CASES OF EXCISION OF THE VERMIFORM
APPENDIX FOR PERFORATIVE
APPENDICITIS, WITH EXHI-
BITION OF FIVE OF THE
PATIENTS.

BY THOMAS G. MORTON, M. D.,
OF PHILADELPHIA.

(Continued from Vol. XXII, page 489.)

In presenting the foregoing cases, I feel warranted in making a few practical observations upon the operation of removal of a diseased appendix; its relations to typhlitis and peritonitis; and especially upon the time and indications for operation, with the details of treatment before and after operation. One thought naturally presents: it is that only a short while ago, under the ideas then prevailing with regard to the treatment of such cases, each of the patients here presented would either have perished, or would be living in constant fear of the repetition of an attack which might at

*Read before the College of Physicians of Philadelphia, Jan. 1, 1890.

diseased appendix and excising it, thus removing the cause of repeated attacks in simple or in perforative appendicitis, it is interesting to note the gradual development of the procedure.

Mr. Hancock, of London,† in 1848, appears to have been the first to urge operative interference in perityphilitic abscess by free incision and drainage, but this did not meet with much favor until it received the endorsement and able advocacy of Willard Parker,‡ in 1867.

In 1878, Sands, of New York, was able to report twenty cases treated in this way, and in 1883, William Pepper, at a meeting of the Pennsylvania State Medical Society, presented the statistics of one hundred cases contributed by Noyes, of Rhode Island. From these, and numerous other contributions to the literature of the subject, it was fully and finally demonstrated that surgical interference in cases of so-called perityphilitic abscess largely reduced the mortality of this affection. This was a decided step in advance upon the old method of non-interference, which, strangely though it may appear, is still advocated in some medical text-books. Surgical writers, on the contrary, now generally urge early operation, which, as has been shown, does not increase the risk to the patient, but places him in a position greatly more favorable to recovery.

After the remarkably successful abdominal surgery of Tait, Keith, and others, had shown that the peritoneal cavity might be opened and explored with comparative impunity, it was but natural that surgeons should be led to apply the same rules to the treatment of perityphilitic abscess, and open it more freely than before; then to explore its cavity, examine the vermiform appendix, and to amputate this unnecessary and dangerous organ when the subject of appendicitis or ulceration, whether perforating or not. This has been the final step in the operative treatment of perityphlitis.

To the diagnosis, indications for opera-

tion, and details of treatment before, during, and after surgical interference, I shall now direct attention.

Diagnosis:—One of the earliest and most constant symptoms of acute appendicitis is pain, which may be slight or stabbing in character, and usually is increased very much by pressure. It comes on in attacks or paroxysms (which may be years or months apart), during which there may be nausea, and even vomiting, but not necessarily. The temperature is slightly elevated; constipation is commonly present; the pulse is generally accelerated; the ileo-caecal region may be tympanitic, or it may be more or less dull. These symptoms sooner or later may disappear, and convalescence be established, but a relapse or recurrence would indicate that a source of irritation continues. After a variable period the attack is renewed, and perhaps with graver symptoms, or, during an apparently mild attack, the sudden advent of violent, local and constitutional symptoms announces very positively the occurrence of inflammation of the appendix, with pus-formation, or peritonitis.

The fact of occurrence of an attack of appendicitis, although apparently entirely recovered from, is serious enough to give rise to apprehensions for the future, for the patient is liable at any time, from a blow, fall, undue exercise, straining, indigestion, or even without apparent cause, to have a recurrence of irritation in the appendix, which may terminate in inflammation, ulceration and perforation. The number of attacks or relapses or recurrences before ulceration takes place varies, but when several have occurred, it is almost certain that the appendix is seriously diseased. After one or more attacks the patient may remain apparently well, but, as a rule, this is not the case, and attack upon attack at gradually shortening intervals very conclusively demonstrate that the appendix is the source of the trouble, and that perforation, if not actually present, is liable to occur at any time. The subject of such an attack may occasionally

†London Medical Gazette, 1848, p. 547.

‡Medical Record, N. Y. 1887.

recover without surgical interference, through atrophy of the organ or adhesion to the cæcum with more or less complete obliteration of its calibre. But such a favorable result must be the great exception in the vast number of cases, and its occurrence in any given case cannot be depended upon.

In cases presenting the symptoms above mentioned, pain, tenderness, deep swelling, or tympanites in the appendix region, associated with prostration, nausea, fever and constipation (these phenomena coming on suddenly), and especially where there has been a history of previous attack, such an array of symptoms would warrant the diagnosis of appendicitis. When to these symptoms is added a sudden accession of intense pain on pressure in the right iliac region, with perhaps moderate pain over the rest of the abdomen, a fluctuating temperature reaching 102° , or perhaps higher, slight rigors or decided chills, moderate perspiration or decided sweating, and an increase of tympany over the peri-cæcal region, unquestionably there will be found pus.

It is also usual in abscess formation to have a dusky or sallow skin, an anxious expression, and prostration.

In a case presenting the symptoms of pus, with a history of former attacks of pain, or relapses, it is certain that we have to deal with an abscess, the result of appendix perforation:

In case of doubt, rectal exploration might be cautiously resorted to, but, owing to the sigmoid flexure being attached upon the left side, it would only rarely occur that this could yield any positive information.

In a small recent abscess it is scarcely probable that it could be discovered through the rectum, while if the abscess was large and encysted there would be no difficulty in detecting it through the abdominal walls.

The use of the aspirating needle I mention but to condemn. It should never be used, for, if it does not find pus we cannot be sure that none is present, while its own dangers are not inconsiderable.

It is in these cases a poor and especially unsafe diagnostic resource.

Differential Diagnosis from Disease of the Cæcum.—From disease of the cæcum the diagnosis of appendicitis cannot always be clearly made, so close is their relation; both giving rise to local disturbance in the right iliac region.

In the region under consideration we have the cæcum and vermiform appendix; both are invested, through more or less of their extent, with peritoneum; both organs are subject to irritation, inflammation, ulceration and perforation. While it is extremely rare to have a perforation of the cæcum, it is just the reverse as to the appendix. Abscess around the cæcum in almost every case is due to appendix disease; even in those cases where cæcal perforations have occurred it is highly probable that they may have resulted from appendix perforation or disease. One such case came under my observation. On the second day after the removal of a gangrenous appendix, feces came from the wound in considerable amount, and upon careful inspection two gangrenous perforations were found involving the anterior and lower part of the cæcum. At the time of the appendix removal the cæcum and colon were somewhat impacted, and the violent inflammation about the appendix had extended to and involved the intestines, gangrene resulting, due in part to contiguous inflammation and also in part to *impaction*. But if this abscess cavity had been simply opened and the appendix not reached, the subsequent appearance of feces would at once have established the diagnosis of simple cæcal perforation, while the appendix disease would have been overlooked. So that in supposed cæcal perforations, primary ulceration of the cæcum being extremely rare, the probability is that it is secondary to appendix disease.

Between perforative cæcitis and perforative appendicitis, the history of previous attacks of pain would make the diagnosis in favor of the latter, even without the history of relapsing typhlitis,

it would be fair to accept the diagnosis of appendix disease, for cæcal perforations are exceedingly rare indeed, but three or four such cases have, it seems, been reported and verified by post-mortem. The necessity for abdominal section is the same in both, so that the diagnosis can be left open in cases of uncertainty, until section is made.

From Acute Intestinal Obstruction.—A careful examination of the patient will usually exclude fecal impaction, intussusception of the bowels, internal strangulation, or volvulus. In ordinary fecal impaction there are no general symptoms, although there may be nausea or vomiting; there is no special pain or tenderness, and the outline of the colon can be made out by palpation. There is usually a history of increasing constipation for weeks or months previous. Intussusception is accompanied by frequent desire to empty the bowels, with discharges of mucus or blood; the tumor is sausage-shaped and is not very tender; and the true character of the case may often be discovered by rectal examination. In volvulus there is more pain, but it is referred to the neighborhood of the umbilicus; there is neither pain nor tenderness in the iliac region. Strangulation may be caused by diverticula and frequently by constriction bands, the sequence of former peritonitis. The intestines may be adherent to the omentum and become revolved upon it. In one case an adherent appendix vermiciformis strangulated the ileum. Obstruction may also be simulated by enteritis or peritonitis, owing to the paralyzing effect upon the bowel. When the obstruction is intestinal the symptoms advance very rapidly, even more so than in appendicitis.

From Spinal or Perinephritic Abscess. Attention to the history of the case and to the local signs of disorder will enable us to diagnosticate these forms of abscess. The treatment being almost identical, at least as far as laparotomy is concerned, we need not waste much time in making refinements of diagnosis, although such diagnosis can generally be made. In the following case, it was not positively

made until some time subsequent to the operation.

In November, 1888, I saw in consultation with Dr. Bartleson, of Clifton Heights, a young man twenty-eight years of age, who had been confined to his bed for three weeks, and presented symptoms of pus formation in the inguinal region. His temperature fluctuated between 100° and 104°; he had sweatings and pronounced chills; yet the pain, which was local, was not severe, but it was increased by pressure. He had no history of former pain in the appendix region. There was, however, a tumor which could readily be made out, but at a considerable depth; I decided to explore this by operation. Incision opened into an abscess, but the cavity seemed closed, and it was not so deep as I had usually found in suppurative appendicitis. Neither the cæcum nor the appendix came into view, nor could they be found in the cavity or its borders. The pus cavity was drained, and subsequently closed. The case subsequently proved to be one of psoas abscess, originating in the lumbar vertebræ, but no positive diagnosis could be made for several months after operation, by which, nevertheless, he was completely cured of both abscess and the spondylitis.

In psoas abscess, especially in young children, some difficulty may be experienced, at times, in differentiating it from pericæcal inflammation. But in the former there is generally a history of long present ill-health and pain in the dorsal region, usually with symptoms of vertebral disease (*i. e.*... gastric irritation, intercostal pains, constriction bands, or pains in the thighs). The pains are colicky and associated with flatulence; and there is more or less pain or irritation of the bladder. Abscess from disease of bodies of the spine generally points in the groin, either just above or below Poupart's ligament; it is associated with a history of ill-health, and difficulty in walking. Iliac abscess may occur unconnected with the spine or cæcum; arising within the abdominal cavity near the spine. In such cases the symptoms of

systemic disturbance are quite decided : chill, more or less pronounced, with hectic fever and night sweating are very apt to occur. As soon as the existence of pus is recognized, an exploratory incision should be made in order to detect the source if possible.

Tumors may appear in this region, both malignant and non-malignant, and their nature may be inferred from their physical characters and the clinical history, which shows their gradual increase in size, etc.

The history of the mode of onset or invasion of the disease will be of service in making its diagnosis. Strangulation of the bowel, intussusception, peritonitis, volvulus, generally come on very suddenly. Impaction of feces, psoas or iliac abscess, and tumors come on gradually. Cæcitis and perforative ulcer of the cæcum are also more or less rapid in their course, and point superficially more quickly than does the abscess to which appendicitis gives rise.

Treatment :—The treatment of pericæcal inflammation, no matter whether its origin is in or about the cæcum or in the appendix, may be divided into two divisions, that of the pre-purulent and that of the post-purulent stage ; or, first, before formation of pus or of appendix perforation ; and, secondly, after that event.

The treatment of the pre-purulent, irritative, catarrhal, or simple inflammatory disorders of the cæcum, its surroundings, or the appendix, should consist in absolute rest in bed, restriction of diet to nourishing liquid, hot poultices or fomentations frequently replaced upon the parts, perhaps local depletions, and possibly the hypodermic exhibition of morphine to control pain ; while the bowels should be kept open and free from accumulations of gas and feces by the administration of calomel or salines and enemas.

Prompt resolution should take place in cases which are not to go on to the stage of pus formation. Tedious recovery, relapse, or recurrence of symptoms, would point to the probable presence of

conditions exceedingly dangerous to the patient from the liability to general peritonitis or perforation at any time, any further, they would point, as a rule, to the appendix as the source of irritation and danger.

That treatment of pericæcal inflammation, which places the bowels "at rest" from the start, or in "splints," commonly so-called, has probably been the cause of more serious, often fatal, results, than can well be estimated. The use of opium without question makes the symptoms which indicate pus-formation, causing loss of diagnostic symptoms and of valuable time at a most critical period ; the apparent improvement due to lack of pain, often causing postponement of operative interference until the patient is practically in a hopeless condition. Intense pain is more an indication for operation than for morphine ; the knife will remove both pain and danger and give radical relief for all time, as recurrence cannot occur when the cause of the malady, the appendix, has been removed.

In the second division, the process has gone beyond the simple irritative or inflammatory stage and pus has formed,

Pus in contact with, or in the cavity of, the peritoneum (and such is precisely the situation in abscess surrounding the appendix or cæcum), is vastly more serious than would be an abdominal for its relief. So the diagnosis of pus having been made, and, indeed, often without positive diagnosis, operation is positively indicated ; many other risks are to be taken rather than those of general purulent peritonitis, for early interference will save almost if not all cases from this much dreaded complication, while the danger of operation becomes slight compared with that of general abdominal inflammation.

Local or general peritonitis supervening in a person who has a history of cæcal trouble would more than justify operation.

At a later, or even, perhaps, in the chronic stage of the disorder, all available diagnostic skill must be exerted when pericæcal abscess may have pointed in an

anomalous situation, and we must ever adhere to the modern surgical rule, always to attack pus at its source, if possible. When the cæcum is normally placed, this is always feasible, if the disease be recognized.

Preparation for the Operation.—There is generally, from the very nature of the case, very little time for any special preparatory treatment.

The field of operation should be made clean with soap and water, then shaved, washed with ether or turpentine, soapsuds again, and then douched with a mercuric chloride solution (1 to 1000); the umbilicus having been carefully cleansed and its cavity rubbed with iodoform.

If possible, the disinfecting process should be completed some hours before, and the abdomen kept covered with a wet bichloride dressing. The field of operation should be protected by towels wrung out of hot mercuric solution.

The instruments should be treated by boiling, and then kept in a three per cent. carbolic acid solution, or used from cooled boiled water.

The operator and his assistant—one is sufficient—should likewise observe the rules of strict antisepsis, which should rigidly prevail throughout.

Operation.—The line of abdominal incision should be lateral, not median. The advantages of the former are very obvious and positive. It is made directly over the appendix region and abscess cavity. If a median incision were made the peritoneal cavity would not only be often needlessly opened, but the section would be at a point remote from the cæcum and appendix, in a position in which they cannot well be reached. Indeed, it would often be quite impossible to deal with a diseased appendix unless the incision were lateral, for the difficulties experienced in bringing into view and separating this organ when it is firmly bound by adhesions to the cæcum, as is often the case, are not inconsiderable. If pus have gained access to the peritoneal cavity, or the intestines come to view, thorough cleansing can be effected

as well by a lateral incision, while the sloughs of cellular and other tissues, which always may be expected from the abscess cavity and surrounding parts, can more readily discharge through an opening contiguous to the disease.

Usually there occurs within a few hours after operation great swelling of the wound and ileo-cæcal region. This requires removal of the sutures; the wound gaps and the cæcum is fully exposed, but the latter is held naturally in position, and there is no danger from intestinal protrusion; drainage by such a free opening is proportionably favored.

The incision should be from four to six inches in length and correspond with the appendix region: it should extend from an inch above the middle of Poupart's ligament upward through the right linea semilunaris and down until peritoneum, cæcum or pus is reached. Occasionally pus is not discovered until the cæcum is displaced, when the abscess cavity and the appendix come in view. Bleeding should be arrested by the use of hæmostatic forceps and the application of hot water.

I have found that the appendix is normally situated immediately under a point two inches distant from the right anterior superior iliac spinous process, on a horizontal line, drawn from this process toward the median line of the body, so that this incision is directly over the organ. When the abscess cavity is reached, gas may be first discharged, then, when pus, which is always offensive, has been reached and sponged or washed away, the appendix is found either lying free or attached to the cæcum or abscess wall. It is not always an easy matter to distinguish the appendix; on one occasion this organ and an epiploic appendage, each the same size and resembling each other in general appearance, were side by side and both firmly glued to the cæcum. The most inferior of these bodies was correctly judged to be the appendix. The anatomical relations will always differentiate the appendix.

(To be continued.)

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BALTIMORE, MAY 3, 1890.

Editorial.**SOMETHING PERSONAL.**

Modesty is an excellent virtue if not indulged in to positive self detriment; but a well balanced self esteem should not be looked upon as conceit. The natural pride which we have in our undertakings is the only excuse that can be offered in asking our readers to notice what we hope they will consider improvements; and it may be stated here, that any such improvements or changes made, have been done at the suggestion of our readers, who, after all, are the proper critics and advisers.

The JOURNAL begins its 23rd volume, the 8th year of its existence as a weekly, and the 14th year since its foundation,

with some gratitude to its supporters, and promises for future advancement. In the first place, the publishers have shown their enterprise in various ways. By careful business management and push, they have doubled the circulation in the past year. This increase of the business part of the concern, naturally led to improvements in its dress. The new cover, colored a tasteful blue-granite, has been put on through suggestions made since the JOURNAL has increased in bulk, to give it a more solid appearance. Again and again has the suggestion been made to have the table of contents at the top of the first page, so that it can be bound in with the reading matter. This will be a great convenience, and will be followed during this volume and for the future, if it be found acceptable. Last of all, the whole reading matter of the JOURNAL has been put into new clean type, so that its whole face will have a uniform neat appearance.

As for the columns of the JOURNAL, arrangements have been made for a series of short practical articles to be published during the summer months, together with the regular contributions of original articles, etc. Editorials on special subjects are in preparation by specialists, and arrangements are nearly complete for regular letters from London and Paris, with occasional correspondence from New York Berlin, Vienna, and Rome.

While some may consider such announcements lacking in taste, they are only made in acknowledgement of requests made at different times during the past two years and carefully noted for use, and these words, uttered in no boastful spirit, are but the natural gratitude expressed to those who have shown an interest in the welfare of the JOURNAL.

THE RECENT MEETING OF THE STATE FACULTY.

After a session of four days, the Medical and Chirurgical Faculty closed its 92nd annual meeting last Friday. The work done was not up to previous years in some respects, and the discussions were, as a whole, rather spasmodic, especially the hackneyed subject of anæsthetics bringing men to their feet to tell their little story of what they knew about chloroform, ether, etc. Many good papers were passed over in silence. It is better to have no discussion than a poor one, but the proper method would have been to appoint a member to open the discussion on each subject. This may be done in future. The increase of membership this year infuses new life into the Society. Many men have come in to work, and those from out of the city who complained of the loss of time in a four days' session, may expect next year two sessions a day, for two days, and a lunch for members on each day.

The President and annual orator delivered fitting addresses appropriate to the times. The new President is evidently the member's choice. If he works for the Society "in the chair" as he has done heretofore, great will be the expectations. The sections for next year are some of them excellent appointments and some remarkably poor. The banquet is a good innovation, but if given to the visiting members, they should *all* be invited in advance and should not see the "wheels go around" in its preparation. If the membership does not increase another hundred in the next twelve months, it will not be the fault of the committee on new members.

Correspondence.

THE EFFICIENT DOSE OF QUININE IN MALARIA,

ANNAPOLIS, Md., April 21st, 1890,

Editor Maryland Medical Journal:

DEAR SIR:—Having read your report of the "Clinical Society of Maryland," in your issue of April 19th 1890, in which Dr. C. O. Miller speaks of treating a boy for malaria with quinine in two grain doses, I wish to inquire how many two grain doses were required and at what intervals, to destroy the inter-cellular bodies.

I remember reading in 1866 "Sappington on Fevers." He lived in the West and had most wonderful success in the treatment of malarial fevers and unlike many successful practitioners left a large fortune when he died as the result of his work. His method of administering quinine was when possible one grain every hour for twenty doses, or two grains every two hours for ten doses. I have always thought two grain doses every two hours, was safe and efficient, but in practice I double the dose and interval finding it impossible to make patients do as they are told.

It is the old story of medicine revolving, the latest researches and experiments of the Johns Hopkins Hospital as reported by Dr. Toulmin, demonstrating Dr. Sappington's theory and practice of half a century ago was correct, and it is due to him to state that the "chills" he cured prevailed upon the banks of the Missouri and Mississippi rivers.

I have seen quinine given in malaria fevers in doses from one grain to sixty grains to a boy of fourteen years. Ten grains at a dose is a common matter and in New York twenty grains at a dose is not unusual with the best practitioners. It is time the profession should settle upon a reasonable dose for ordinary cases, and it is hoped many experiments will be made to demonstrate the utility of small

doses of this much used and most abused medicine.

Very respectfully,
J. M. WORTHINGTON, M. D.

[Dr. Harry Toulmin, of the Johns Hopkins Hospital gives, in these cases, two grains of quinine three to four times a day, and he has found that the inter-cellular bodies disappear after the second or third day, and the cases treated by him in this way do not return for further treatment.—ED.]

Reviews, Books and Pamphlets.

The Neuroses of the Genito-Urinary System in the Male, with Sterility and Impotence. By DR. R. ULTZMANN, Professor of Genito-Urinary Diseases in the University of Vienna. Translated by Gardner W. Allen, M. D., Surgeon in the Genito-Urinary Department, Boston Dispensary. Philadelphia and London: F. A. Davis, 1890. Pp. 8 to 160. Price \$1.00.

This is a translation of two of Ultzmann's most celebrated and popular monographs, the contents of which must be so familiar to all who have had the pleasure of attending his clinics. It is only a wonder that they have not appeared in English before. Few men have gone more deeply into the study of the genito-urinary diseases from its medical side than the late Ultzmann. The translation is smooth.

The Examination of Urine, Chemical and Microscopical, for Clinical Purposes. Arranged in the form of Questions and Answers. By LAWRENCE WOLFF, M. D., Physician to the German Hospital of Philadelphia. Colored Plate and Numerous Illustrations. Philadelphia: W. B. Saunders, 1890. Pp. 17 to 66. (Saunders's Question Compends). Price \$1.00.

This manual covers the ground very thoroughly. It is in the form of a catechism. The subject is treated from a clinical rather than a chemical aspect.

On Hysterorrhaphy. By HOWARD A. KELLY, A. M., M. D., Gynæcologist to the Johns Hopkins Hospital and Associate Professor of Gynæcology in the Johns Hopkins University. Reprint from *The Johns Hopkins Hospital Bulletin*, No. 2, January, 1890.

Report of a Case of Tetanus following Ovariotomy, with Remarks. Reprint from *Annals of Gynæcology*, Boston, September, 1889.

A Record of Eighty Miscellaneous Abdominal Operations. Seventh Annual Address of the President, delivered before the Washington Obstetrical and Gynæcological Society, October 4, 1885. Reprint from the *American Journal of Obstetrics and Diseases of Women and Children*, Vol. XXIII, No. 2, 1890. By JOSEPH TABER JOHNSON, A. M., M. D., Ph. D., Professor of Gynæcology in the Medical Department of Georgetown University, etc., Washington, D. C.

Hospital Reports.

PRESBYTERIAN EYE, EAR AND THROAT CHARITY HOSPITAL.
MONTHLY REPORT FOR APRIL.

BY JULIAN J. CHISOLM, M. D.

Surgeon-in-chief of Hospital.

New cases entered for the month of April.	721
Aggregate of daily visits for the month of April.	3,383
Average of daily attendance at the Free Dispensary.	130
Number of new cases since Jan. 1st, 1890.	3,694

Number of visits paid the institution by the patients.	12.710
Number of operations since Jan. 1st, 4 months.	500
Number of operations for month of April,	112
 AMONG THESE WERE ;	
Cataract Extractions, . . ,	11
Capsular Cataracts, division. . . .	2
Glaucoma, Iridectomy.	1
Closed Pupil, Iridectomy.	5
Hernia of Iris, Iridectomy.	2
Tarsal Tumors.	11
Internal Squint, Tenotomy,	6
External Squint. Tenotomy.	3
Enucleations of Lost, Painful Eyes.	4
Neurotomy Optico-Ciliary to stop Pain in Lost Eye.	1
Lachrymal Abscesses, opened. . . .	2
Mucocele Canalculus Section. . . .	2
Entropion.	1
Dermic Tumor of Conjunctiva, Co ngenital, removed.	1
Foreign Bodied Removed from Cornea.	19
Hordeolum Opened.	1
Warts Removed from Lids.	1
Abscesses of Lid.	2
Ceruminous Plugs Removed.	26
Keloid Tumors Removed from Ears.	2
Abscesses of Ears Opened.	2
Nasal Polypi,	2

Miscellany.

THE WILLIAM F. JENKS MEMORIAL PRIZE.

The Second Triennial Prize, of Four Hundred and Fifty Dollars, under the Deed of Trust of Mrs. William F. Jenks, will be awarded to the author of the best essay on "The Symptomatology and Treatment of the Nervous Disorders fol-

lowing the Acute Infectious Diseases of Infancy and Childhood." The conditions annexed by the founder of this prize are, that the "prize or award must always be for some subject connected with Obstetrics, or the Diseases of Women, or the Diseases of Children ;" and that "the Trustees, under this deed for the time being, can, in their discretion, publish the successful essay, or any paper written upon any subject for which they may offer a reward, provided the income in their hands may, in their judgment, be sufficient for that purpose, and the essay or paper be considered by them worthy of publication. If published, the distribution of said essay shall be entirely under the control of said Trustees. In case they do not publish the said essay or paper, it shall be the property of the College of Physicians of Philadelphia."

The prize is open for competition to the whole world, but the essay must be the production of a single person.

The essay, which must be written in the English language, or if in a foreign language, accompanied by an English translation, should be sent to the College of Physicians of Philadelphia, Pennsylvania, U. S. A., before January 1, 1892, addressed to Louis Starr, M. D., Chairman of the William F. Jenks Prize Committee.

Each essay must be distinguished by a motto, and accompanied by a sealed envelope bearing the same motto and containing the name and address of the writer. No envelope will be opened except that which accompanies the successful essay.

The Committee will return the unsuccessful essays if reclaimed by their respective writers, or their agents, within one year.

The Committee reserves the right not to make an award if no essay submitted is considered worthy of the prize.

WOMAN'S MEDICAL COLLEGE COMMENCEMENT.

The eighth annual commencement of the Woman's Medical College of Balti-

more was held last Thursday afternoon in the presence of a large audience. The platform was decorated with flowers, evergreens and palms. Seated on the platform was the faculty of the college, consisting of Drs. B. B. Browne, T. A. Ashby, Randolph Winslow, dean, E. F. Cordell, Wm. D. Booker, R. H. Thomas, J. G. Jay, Amanda Taylor Norris, Hiram Woods, Joseph T. Smith, John R. Winslow, Pearce Kintzing, C. O. Miller, George R. Graham, E. E. Mac kenzie, J. F. Martenet, H. Hare, I. M. Cochel, J. W. Lord, and Dr. C. C. Bom baugh, the orator of the occasion.

Dr. Randolph Winslow, dean of the college, gave a short history of the college. The object of the institution was to afford to women the opportunity of studying medicine in a properly conducted college, and qualifying themselves for the practice of the healing art. That women have elected to study medicine is a fact well known to all, and the incorporators of this institution, rightly discerning the signs of the times, resolved to place themselves and this city in line with New York, Philadelphia and Chicago in offering to women of this and other States favorable opportunities for acquiring a thorough theoretical and practical education in the science and art of medicine. In order to supply the need in a special direction, the Woman's Medical College sprang into existence in the early part of 1882, and since then a high standard has been maintained, so that for years the grade of this college has been far higher than that of any medical school in the city. During the past eight years 27 have finished their course and taken their degrees. A number of them are now practising their profession in this city. What is now needed is a liberal endowment for the erection of better and more commodious buildings, for the purchase of scientific apparatus, &c. Dr. Winslow announced the graduates as follows: Mary L. Burgess and Donna Waldran, of Tennessee; Claribel Cone, Hattie M. Frist, Caroline W. Latimer, Marion Anne Watson, of Mary-

land, and Louise Z. Smith, of Nebraska.

After the degrees were conferred the gold medal from the faculty was awarded to Claribel Cone, of Baltimore, for excellence in examinations. Miss Cone also received the prize for the best examination in the practice of medicine. Dr. C. C. Bombaugh then delivered the valedictory address.

SAUERKRAUT IN THE TREATMENT OF GASTRIC NEUROSES.

Nouveaux Remèdes, quoting from Franz Heller (*Wien. med. Presse*), who has made experiments on himself and others, states that this author suggests sauerkraut at meals as the best remedy for chronic nervous or anæmic dyspepsia. Dyspeptic symptoms—such as regurgitation, difficult digestion and eructations—disappear in a short time. An effort was made to replace sauerkraut by dilute hydrochloric acid—four drops in water—but without favorable results. Red cabbage was also without avail.—*N. Y. Med. Jour.*

CODEINE IN OVRIAN PAIN.

Dr. Freund, of Strassburg, has recently used codeine in a large number of cases of abdominal pain from various causes, with the view of testing the assertions of Dr. Brunton that the drug is of especial use in intestinal or pelvic pain. His results seem to indicate that Brunton's views are somewhat exaggerated.

Pain from acute uterine affections, such as dysmenorrhœa, Freund found, was not as quickly relieved with codeine as with morphine, and the relief was of shorter duration. In pain from pelvic exudates and tubal disease the drug was also of but little value. In ovarian pain, however, whether from prolapse, oöphoritis, peri-oöphoritis, or neuralgia, the relief afforded by codeine was prompt, unmistakable, and more or less permanent even when small doses were given. The amount usually administered was about half a grain three times daily in pill form, and in but few cases was it

necessary to increase this quantity. His experience coincides with Brunton's that no disagreeable or harmful effects follow the use of the drug. It does not stupefy, diminish the appetite, nor constipate. He prescribes the pill for one month after an attack of ovarian pain, and warmly recommends the drug for the above conditions.—*Therapeutische Monatshefte*, Nov. 1889.—*Medical News*.

PROPHYLACTIC TREATMENT OF HEREDITARY TUBERCULOSIS.

Proper food and proper feeding are of great importance. If the mother is healthy she should nurse the child. If artificial feeding is necessary the food should always be boiled.

Open air is the most precious of all the ailments for such children. Salt baths should be advised, using 125 grammes of common salt to 20 quarts of water.

The child should be put into such a bath for five minutes, at a temperature equal to that of the room and rubbed briskly afterwards. Sea baths are to be advised with caution, and stopped the moment there is the slightest bronchial trouble. As to medication, the best embraces iodides, arsenic, cod liver oil, phosphate of lime, and tannin. The following formulæ are given :

R. Potassium iodide . . . grs. vii
Tincture of iodine . . . grs. vii
Cinchona syrup . . . ʒ iv

M. S.—Teaspoonful dose according to age.

Or :

R. Iodide of sodium . . . ʒ ss
Glycerin
Bitter orange-peel syrup ʒ ii

A dessertspoonful of this per day is enough for a child of three years of age. Arsenic is not given before the child is three or four years of age, and then in half-drop doses. Cod-liver oil may be commenced as soon as the baby has done nursing.—*Archives of Pediatrics*.

TEST FOR THE PURITY OF WOOLEN GARMENTS.

According to the *Sanatarian*, the genuineness of woolen clothing may be tested by placing a small fragment in caustic soda, which quickly destroys animal fibres, but has no effect upon those of vegetable origin. If the article is all wool it will be completely dissolved; if it has a groundwork of cotton the latter will remain.—*Med. News*.

Medical Items.

The wife of Dr. John B. Hart of Waverly, died last week.

Prohibition in South Dakota is causing some inconvenience in the drug stores there.

The police physicians, Drs. Smith, Wood and Heard, were reappointed by the Police Board.

The exodus of Baltimore physicians for Europe this summer will be very great. A few have already left.

A German proverb says that "A physician is an angel when employed, but the devil when one must pay him."

The cleaning of the six hundred miles of streets in New York costs about \$1,000,000 annually.

Dr. Sidney O. Heiskell, quarantine physician, has appointed Dr. John W. Branham as assistant for the quarantine season.

The spread of the English Language is indicated by the fact that it was used in the framing of a recent treaty between Russia and China.

Among the legacies of the late Hon. Daniel B. St. John, of Newburgh, N. Y., was one of ten thousand dollars to the New York Post-Graduate Medical School and Hospital.

The recent play so successfully given at the Lyceum, under the auspices of the lady managers, will yield over \$2,000 for the Maryland General Hospital, which is under the control of the Baltimore Medical College.

A case of leprosy has been discovered among the passengers on a Cunard Steamer landing at Boston recently. As it is not probable that the disease developed on the steamer, blame rests on the Liverpool authorities who will have the pleasure of receiving the case back from this country,

Dr. George W. Miltenberger has resigned the chair of obstetrics in the University of Maryland, and the Faculty has seen fit to appoint Dr. J. Edwin Michael in his place. Dr. Miltenberger, who has been connected with the University for fifty years, has received the title of Emeritus Professor and Honorary President of the Faculty.

With the exception of the late Dr. Nathan R. Smith, Dr. Miltenberger is the only person upon whom the title of Honorary President has been conferred. The new professor of anatomy has not yet been announced, but the Faculty's choice is pretty well understood.

The new officers of the Medical and Chirurgical Faculty for 1890-91 are: Dr. T. A. Ashby, president; Drs. Geo. H. Rohé and J. McPherson Scott, vice-presidents; Dr. G. Lane Taneyhill, recording secretary; Dr. Robert T. Wilson, assistant secretary; Dr. J. T. Smith, corresponding secretary; Wm. B. Canfield, reporting secretary, and Dr. W. F. A. Kemp, treasurer. Executive Committee, Drs. P. C. Williams, S. T. Earle, A. Friedenwald, J. W. Chambers, and R. Winslow. Examining Board of Western Shore—Drs. C. H. Jones, B. B. Browne, Wilmer Brinton, J. E. Michael, L. E. Neale, J. D. Blake and J. H. Brantham. Examining Board of Eastern Shore—Drs. B. W. Goldsborough, G. T. Atkinson, A. H. Bayley, J. K. H. Jacobs and W. F. Hines.

A handsome new building for the College of Physicians and Surgeons will be erected shortly upon the site of the old City Hospital. Drs. Charles F. Bevan and Thomas S. Latimer, the committee submitted their report on the improvements to the faculty recently. The plans are now in the hands of the architects. The architecture of the new building will be in keeping with that of the new City Hospital, adjoining. The new building will be of Potomac red sandstone, 75 by 100 feet, with an imposing main entrance on Calvert street similar to that of the new hospital. An entrance will also be made on Saratoga street, to lead into a hall running north and south. A hall on each floor will divide the east from the west section. There will be three floors, topped by a mansard roof. The main entrance, on Calvert street, will lead into a fine vestibule on the ground floor. The general dispensary will be in the middle of the eastern section, on the ground floor, and will be lighted by a skylight. Along the Saratoga street wall and the one opposite will be ten special consultation rooms. In the northeast corner will be drug room, adjoined by that of the private physicians. The second floor will be occupied by the offices and private rooms of the resident physicians and students, the medical library—a new feature—the faculty room, and a ward for night accidents and cases of emergency. The lecture room will be in the west section. The third floor will contain three rooms, the east section containing the chemical and physiological laboratories, and the west section the operation room and amphitheatre, with 400 folding chairs. The hospital, built by the city 60 years ago, was a public school until early in the sixties. It was then bought at public auction by the Washington Medical College of Baltimore, and became the Washington University Hospital until that institution merged into the College of Physicians and Surgeons in 1877.

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VOL. XXIII. No. 2. BALTIMORE, MAY 10, 1890.

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ABORTION AND ITS EFFECTS.*

BY JOSEPH TABER JOHNSON,
A. M., M. D., PH. D.,
OF WASHINGTON, D. C.

Professor of Gynæcology in the University of Georgetown, etc., etc.

Mr. President and Fellows of the Medical and Chirurgical Faculty of Maryland: It will be especially difficult for me to interest the members of this ancient and honorable Faculty, after suchmen as Billings, Weir Mitchell, Goodell, Osler and Welch have entertained and instructed you by their eloquence and wisdom.

Statistics of libraries and museums, the vagaries of the nervous system, the dangers and duties of the hour, the infectiousness of disease, and the license

to practise, are all subjects which are full of interest, and have been ably presented. I presume the committee expected me, as a gynaecologist, to discuss some topic in this branch of medicine or in abdominal surgery, and I fully intended to do so, but when I began to write it occurred to me that only a small proportion of the membership of a State Society would be interested in a special topic, and I shall therefore make no apology for introducing a subject, which, though not of very savory odor, yet is of great interest to every member of the profession, whether he be young or old, a specialist or general practitioner, professor or student.

I shall ask your attention, then, without further preface or delay, to the importance, the frequency, the wickedness, and to some of the effects of procured abortion.

All writers upon obstetrics and gynaecology admit and deplore the frequency with which the immature foetus is expelled from the uterus.

*Annual Oration delivered April 23rd, 1890, before the Medical and Chirurgical State Faculty of Maryland at its 92nd Annual Session.

Thomas has an entire volume upon abortion now in press and soon to be published, the advance sheets of which I have been kindly allowed to read. Writers upon domestic economy, upon vital statistics, upon the natural increase and decrease of our population, upon law, theology and medicine, all vie with each other in attesting the importance and wickedness of forced abortion, and all, so far as they mention this point, agree that it has not only been distressingly frequent in the past, but that it has been steadily upon the increase. So much do I believe this to be the case and so far-reaching are its effects upon the health and morals of our people, that I hazard nothing when I declare that this subject is *one* of the most, if not *the* most important question before our profession to-day.

Questions of drainage, sewage, quarantine, vaccination, antiseptics, are all important in the prevention of disease, and have doubtless saved thousands of lives, but they all sink into insignificance in comparison with the importance of the subject under discussion. I believe that statistics might be adduced, if time and your patience would permit, to show conclusively that more lives are annually sacrificed by the unnecessary and intentional destruction of the human foetus, than are saved by all these agencies combined.

The recognized and described causes of abortion show that it occurs once to every five labors, and that 90 per cent. of all married women have at least one miscarriage during their child-bearing life. These are frequent enough to excite the sympathy and invoke the aid of the profession, but I refer now more especially to that larger class, where there is a violent and premature expulsion of the product of conception, independent of its age, viability, or normal formation, where it is artificially induced and intentional, and where it is not necessary for the safety of the mother, and would not otherwise have occurred. Some of the Legislatures of our older

States have been so alarmed at the lessening of their population that they have appointed committees to investigate into the causes thereof; and Dr. Nathan Allan of Massachusetts, in his report upon this subject, said that the native American stock of that State seemed to be dying out. He mentions small towns and cities where the only increase in the population was among those of recent foreign origin, and that in those cities and districts mostly populated by native American families, there were recorded more deaths than births; that one hundred years ago it was rare to see families of less than six children, and frequently there were ten; now it is rare to find as many as three, and often only one, or none at all. Grave apprehension was expressed in this report, made more than twenty years ago, for the results which were then pointed out, and which seemed sure to follow.

These results have been more than realized in that State. These foreign children have become of age and are now voters. The same influences have been at work during this generation as in the last, in an increased ratio; and to-day the proud city of the puritans, cultured Boston, has become almost, if not quite, an Irish and a Catholic city, rejoicing in the possession of a Mayor by the classic name of O'Brien. So long ago as 1857 the American Medical Association became aroused on this subject, and at its meeting in Nashville in that year appointed a committee of eight prominent and able men, to report upon criminal abortion, with a view to its general suppression. A report was made in May of the next year, at Louisville, which, with the resolutions accompanying it, were unanimously adopted. At a subsequent meeting a popular prize essay was authorized by the Association in which the wickedness of the crime should be set forth, its frequency condemned, and its injurious effects fully explained, so that any woman could easily understand. The essay accepted was written by Dr. H. R. Storer, of Boston, and was entitled "Why Not?"

Or, A Book for Every Woman." A very large number were printed and were placed for sale in the book-stores throughout the length and breadth of the land. Medical, secular and religious journals commented favorably upon the essay, and the frequency and criminality of abortion was clearly set forth, and its perpetrators were severely denounced. I have thus far and from official testimony endeavored to show the importance of my subject and the views which were held by the highest medical body in the land upon its importance, and the great need which existed for its suppression. It has also been shown that at least two States in our Union had become so alarmed over the decrease in the American element of their population, that legislative action was taken for its discovery and prevention. Very interesting and instructive reading may be found in the reports of Dr. Nathan Allan, of Lowell, and Dr. Snow, of Providence, upon this subject.

From the same sources which proved to Dr. Storer and the American Medical Association the frequency of this crime, we can now gather greatly increased and multiplied testimony that this wanton, unnatural, unnecessary and basely wicked destruction of foetal life has not only *not* been suppressed in obedience to unanimously passed resolutions, but that it constantly has been, and is now, largely upon the increase in our country, and for that matter throughout the entire civilized world.

This crime is not indigenous to any location, section, climate or continent. Its perpetration is as world-wide as are its murderous and otherwise injurious effects upon those engaged in this unholy warfare. Storer showed, in 1866, from indisputable evidence, that abortion and still-births were twelve times more frequent in some of our cities than the worst statistics had ever shown to exist in Paris or Vienna. From the same reasoning we cannot believe that a better condition exists in those cities now; on the contrary, we are forced to the conviction that unnecessary abortions are made to

occur in a greatly increased ratio, and that the country districts, usually the most pure and upright in their morals, are not far behind the cities in proportion to their population in their destruction of foetal life.

American families have not increased in size, and no facts exist to prove that the fecundity of the men and women has in any way been lessened by the advances in civilization.

The evidence of physicians could be adduced, if necessary, to demonstrate these facts. Vital statistics might be quoted to show that in the true American stock in some parts of our country the ratio of deaths over the births has steadily increased. The published number of maternal deaths from this malpractice does not appear to be decreasing.

The arrests and trials for abortion, while they may in a very faint degree indicate its frequency, do, on the other hand, and in a very emphatic manner, demonstrate the laxity of morals and the law in permitting so many of the guilty to escape their just punishment. The obstacles to conviction, the difficulties of proof, the inefficiency of the law, as well as the evident lack of a desire to convict, on the part of all those engaged in these trials, may explain the fact that of the 32 arrests and trials of abortionists reported by the Attorney General of the State of Massachusetts, in a period of eight years, not one single conviction resulted.

Englemann says, "Abortionists everywhere are known. In the larger cities of this continent, as well as Europe, they achieve a widespread fame, are well known, and yet rarely, if ever, convicted. It is a notorious fact that these worst of criminals almost invariably escape, and even in the States of Germany, where the laws are strict and rigidly enforced, where the crime of abortion is punished by imprisonment of from four to twenty years, that eminent teacher of medical jurisprudence, J. L. Caspar, says that of all the many accused, never a one was condemned, and in no one case was the crime proven. They are sheltered

by the words of the law and the sympathy of the community."*

In many cases the arrest and trial is not for the crime intended. The intention is, and of necessity must always be, to kill the foetus; this being done in the dark, like other deeds of evil, there are no witnesses, and the crime usually escapes public notice, unless a bungler in the art should at the same time injure or destroy the mother also.

There is little or no trouble in securing conviction then, for malpractice; but the indignation of the virtuous public and the majesty of violated law are only then aroused and invoked because the unskilful manipulator killed two human beings instead of one. It is for the crime against the mother which was not intended, but which unfortunately and accidentally happened, that the criminal is brought to trial.

A story is told of a wicked and unjust judge in the early days of the wild and woody West, who, in pronouncing sentence upon a man proven guilty of seduction—a crime which is the twin sister to abortion—stated to him that it was not so much for committing the wicked deed that he sentenced him to hard labor in the common jail, but it was for allowing himself to be caught in the act and making so much public scandal and family exposure.

Another reason given by Storer in his book before referred to, for his belief in the frequency of abortion, is the pecuniary success of known abortionists, and of the venders of abortion-producing nostrums, and again, the experience of physicians on account of direct and frequent applications made to them to commit this crime, and in the immediate and multitudinous after-effects, which they see in their daily practice upon its unhappy victims.

The evidences from these quarters, if they were convincing twenty years ago, have surely lost none of their force and convincing qualities with the lapse of time. The public advertisements of known abortionists in our newspapers

and some religious journals are more public and more numerous now than they were then, and the public display and ready sale of abortion-producing nostrums by our druggists is confessedly upon the increase.

A generation ago these facts were all so fully and completely proven by the able committee of the American Medical Association and set forth in popular language in its prize essay for distribution among the women of our land, that no effort was ever publicly made to gainsay or disprove any of the positions taken—they were all admitted and deplored. The effect for a time was salutary, and its author received letters innumerable from good people and from mothers made happy by the possession of healthy offspring, whose habit it had previously been to resort to abortion.

The public conscience was aroused and the promoters of the move in the Association no doubt congratulated themselves that they had accomplished a great good for society and the State, for morals, law and religion. Secular, medical and religious journals approved, clergymen preached and a sense of security probably settled down upon the virtuous public that another growing evil had been boldly met, the battle against it successfully waged and the victory won; but the sequel in this generation proves that it was no more of a victory than was gained over his creditors by the impecunious Micawber when he gave them his note of hand, and thanked the Lord that his debts were paid.

There is no longer any doubt from a consideration of all the evidences before relied upon to prove its frequency, that abortion is now fully as frequent as it ever was in this country, and, moreover, that it is alarmingly on the increase; not only is this believed to be true of the cities, but the remotest country districts seem to be infected also.

The excuses given are the same now as they were then, and the wickedness of the act is, and always will be, the same. In one respect our otherwise noble pro-

*Article on Abortion, Pepper's System of Medicine.

fession is sadly at fault; it has not acted up to the courage of its convictions. Of a necessity it must be, and I believe that it is, unanimous in the knowledge and belief that the foetus is just as much alive at one period of its intra-uterine existence as another; it must be alive or dead all the time. If alive, it is just as much a crime to kill it in the first month of pregnancy as in the ninth, or after it is born. Our text-books all teach, and our profession holds, that the spark of life is infused at conception, and we must believe, with Percival, that "to extinguish this first spark of life is a crime of the same nature, both against our Maker and society, as to destroy an infant, a child, or a man."

Many otherwise good and exemplary women, who would rather part with their right hands, or let their tongues cleave to the roof of their mouths than to commit a crime, seem to believe that prior to quickening it is no more harm to cause the evacuation of the contents of their wombs, than it is that of their bladders or their bowels. The law itself is largely upon their side in this most important question, the penalties affixed to this crime being slight before quickening and vastly insufficient afterwards. Before a woman is quick with child, abortion being considered simply as a misdemeanor, after quickening as a felony, and only is the child considered sufficiently alive to be killed, in the eye of the law, which ought to protect it, when it has been entirely born and is separated from its mother and living an independent existence. The experience of every physician is, that good women as well as bad, are committing this wrong in utter ignorance of the fact that it is a crime.

They will boldly argue the question and will fully admit its wickedness, after they can feel the motion of the child. They condemn its destruction as a cruel murder after quickening, and would no more be guilty of embruising their fair hands in its innocent blood, after they could feel it move, than they would be accessory to the destruction of their liv-

ing children. The fault of our profession is that this belief exists at all. If we really believe in accordance with the evidence and teaching of our science, that the foetus is alive before quickening, it must be our fault if this dense ignorance longer exists in the minds of our people, and that it so hinders the proper and just administration of the law. If the child is alive, as we believe and teach in the first, second, and third months of pregnancy just as much as it is in seventh eighth, and ninth; then its destruction must be as wicked in one month as another. If the murder of an unarmed man in the dark and behind his back is deemed by all good people as a dastardly and cowardly act, and if the murder of innocent and unprotected children is loudly denounced the world over, what language can be sufficient to express our disapprobation and contempt for those heartless and soulless miscreants who are in the most wholesale and cowardly manner, killing countless numbers of children, who are not even protected by the law. Those who are engaged in the perpetration of abortion should no longer be able to shield their crimes behind this cloak of real or pretended ignorance.

There is not a household in the land or in the civilized world which is not more or less permeated by the influence and teaching of the noble science which we practise, and this ignorance of the law of life, or of the fact of life, before quickening, could, if we were sufficiently alive to its importance, be utterly done away with and wiped off the face of the earth in a single year. Otherwise, good women would no longer boast of the number of foetuses they had gotten rid of, and they would no longer teach their sisters how they could accomplish the same "innocent" feat. When it is known and universally acknowledged that to extinguish the first spark of human life is a crime of the same nature, both against our Maker and society, as it is to destroy an infant, a child, or a man; then, and not until then will abortion cease to be a common occurrence, and good men and women become ready to

assume the responsibility of their own deliberate acts.

The luxuries of life, the demands of fashionable society, the dislike of children, the expense of their maintenance and education, questions of taste, indolence and convenience can no longer be pleaded as an excuse for the committal of a cowardly, dirty, contemptible, bloody, and wholly unnatural crime.

When wholesome laws are enacted and enforced, which will punish not only the principals, but all the aiders and abettors and accessories to this crime, just as they do other murders; then its commission will be confined to those, who, to carry out their wicked purposes, are willing to defy any and all laws, in spite of the disastrous consequences which they invite and invoke to follow. Lawyers and judges need enlightenment upon this subject as well as women; they should learn that we do not, and cannot discriminate between one month and another when the foetus is more or less alive; that quickening amounts to nothing. We all know that some women quicken as early as three, or three and a half months, and others not until six, and some not at all; and who will arise and say that in these late cases of quickening the foetus is not just as much alive as in the early ones, and just as much entitled to the protection of the law?

That life is not infused at quickening we are all agreed. The foetus then being as much alive before quickening as after; the popular belief and convenient ignorance on this point, it becomes the moral and Christian duty of our profession to correct.

The pregnant woman receives a great many hints as the signs and symptoms accumulate and corroborate each other that a live and growing foetus is developing in her uterus, but she now waits for a decided kick before she will believe that the foetus is alive. This kick is waited for anxiously by the woman as well as the law, to announce that the child is sufficiently formed for its destruction to constitute even a misdemeanor.

It must kick very decidedly and un-

mistakably for several months before its killing constitutes a felony, and as one judge has held, should it be knocked on the head with a hammer, or strangled with a garter after its head is born, but before it is wholly delivered and separated from its mother, it is *not* sufficiently alive in the eye of the law, for its killing to constitute murder.

Having drawn attention to the importance, frequency and wickedness of procured abortion, I beg in conclusion to remind you of some of its effects upon the morals and the physical well being of those engaged in this nefarious practice.

By those who in their hearts consider it wrong to destroy the unborn child, there must be an undermining of the moral nature which will show its effects in many other directions than the one under discussion. But of this phase of the subject I will leave others to speak. In one respect, however, it deeply concerns us as well as its unhappy victims.

The remorse which comes to some, over the killing of their unborn children sometimes develops into melancholia and terminates in suicide or the mad house. Many a woman has lost her life by the addition of this depressing element to the slighter forms of septicæmia following a procured abortion. Thus Tardieu reports that of one hundred and sixteen cases of criminal abortion collected by himself in Paris, sixty died outright and many had a lingering convalescence, while out of two hundred and thirty-four cases of abortion occurring from various causes and treated by physicians in the Rotunda Hospital in Dublin, only one died, and the cause of death in her case was from mitral disease of the heart. Lusk, in his classic work on obstetrics says that death in consequence of criminal abortion is especially frequent. Yet of the many cases who enter Bellevue Hospital for treatment, whose histories he has found in the record books of the hospital, all have ended in recovery. Cases of induced abortion in their desire to avoid notice and publicity, frequently fail to properly care for themselves; they get up and about too soon, while the uterus is

still large and heavy, and thereby lay the foundation for future suffering and the life of an invalid.

Hirst, in Mann's System of Obstetrics Pp. 316, says : "Criminal abortions with the additional risks of septicæmia from the unskilful use of instruments, and the probability of infection from unclean hands and implements, would show a surprisingly high rate of mortality if it were possible to collect accurate statistics, which for obvious reasons it is impossible to do."

Englemann says, "woman requires skilled aid in labor, the physiological termination of pregnancy, *more necessary still* is this in the premature pathological interruption of this condition in abortion."

Benninger reported twenty-one cases of tetanus following abortion in the *British Gynaecological Journal* in 1888.

Charpentier in his great work published three years ago says : "the prognosis of abortion for the mother is grave ; for even if life is rarely compromised, health frequently is." He adds further that "the prognosis is most unfavorable in cases where the miscarriage is the result of criminal manipulations."

The American editor of this work says in a note, "miscarriage is fraught with more danger to the woman than labor at term, because as Goodell aptly puts it, the process is like plucking immature fruit."

The occurrence of abortion takes the uterus at a disadvantage. It is immature ; it is not ready to expel its contents ; its contracting powers are not developed, and its contractions are imperfect after as well as before the act. The membranes are especially adherent and frequently, if not always, some portion of them is retained after the premature expulsion of the embryo.

The decidua is soft, enlarged, and its bulky remains easily form the nidus for the development of germs for the future production of septicæmia or menorrhagia. Traumatism is frequently present, inviting the absorption of septic germs and if blood-poisoning in a grave form is fortu-

nately escaped, cellulitis, salpingitis, ovarian or pelvic abscess is liable to develop. Subinvolution and its resulting increased size and weight of the uterus often making the life of the woman a burden from the endometritis, salpingitis endocervicitis and the various uterine displacements which naturally follow as a painful train of symptoms.

These are all rendered more probable from the embarrassing necessity for keeping up appearances and diverting attention and suspicion from their real cause.

These effects of abortion, when it occurs from natural causes and when treated by skilful physicians, are difficult enough to avert, and are only prevented by rest in bed, good nursing and continued and careful preventive measures ; when they occur, however, as they often do, in boarding houses and hotels, and among those women who desire great secrecy to avoid exposure and shame, these attentions are either not sought or permitted. The mental state, added to the physical condition, has proved too great a strain for many an erring woman. Remorse of conscience has been the last straw which has driven some of these unhappy victims of their own error and folly to suicide or insanity.

Convalescence is generally prolonged from these causes, and the patient has many weeks, and perhaps months, if not years, of invalidism in which to regret the errors of an ill-spent hour.

Our free dispensaries and charity hospitals afford innumerable examples of broken constitutions and ruined lives which have had their sad beginning in an improperly treated abortion. It is the usual explanation given by a majority of the frequenters of the gynaecological clinic, that the displacement or inflammation of the uterus for which the sufferer applies for relief—that her symptoms dated back to an abortion, three, five, or ten years ago. Many of the cases now operated on for otherwise incurable pus-tubes, or chronic inflammatory disease of the ovaries, date all their troubles back to a neglected abor-

tion. These sufferings are not all confined to the charity patients in the lower walks of life. They are as common as is the custom of abortion itself. No one rank in society appropriates them all. The experience of gynaecologists the world over will confirm the statement that a majority of the patients that we are called upon to treat in our offices, or in the fine residences of their fair owners, are the outcome of abortions or of the preventive measures used against conception.

This latter subject was fully exposed and discussed not long ago by a distinguished writer and teacher from a neighboring city in an address upon "The Dangers and Duties of the Hour" before this body and upon this platform. This discussion of my subject forms a very appropriate appendix to his masterly oration, and my chief regret is that your committee selected no better man to bring before you the dangers and duties of the hour so far as they relate to this still more important subject. It is an every-day occurrence for ladies to consult busy gynaecologists in our large cities in regard to symptoms, which, upon enquiry, are found to date back to an unfortunate abortion. It would be quite within the limits of truth were I to state that two-thirds of the work of the gynaecologists of this age finds its chief cause in the evils discussed upon this platform by Dr. Goodell and myself. It is a sad commentary upon the Christian civilization of the age; but the experience of honest workers in this department of our science I believe would corroborate the truth of this saddening statement.

Our sadness, however, is somewhat lessened when we are able to state also that the causes which we lament are among those which are demonstrated as preventable. If many err through ignorance we may here find a glorious opportunity for the exercise of the law of prevention. Much has been said of late of the greater mission of our science in the prevention than in the cure of disease. How can a better field of labor be found

than in the direction I have indicated. Where and how can medical men save more lives or prevent more suffering than by teaching women the dangers of abortion and thus saving their bodies, and perhaps their souls, from ruin in this life and the life to come. In this exercise of our great mission we may be sure of the approval of our own consciences, of the co-operation of the great Physician in the prevention of much sin and sorrow, and of the final judgment of "Well done, thou good and faithful servant."

Upon motion of Prof. Wm. T. Howard a unanimous vote of thanks was tendered to Dr. Johnson, for his very timely and interesting address, and a copy requested for publication in the transactions of the Faculty.

926 Farragut Square.

IV. DISEASES OF THE PUERPERAL PERIOD. SEPTICÆMIA.*

BY WILLIAM S. GARDNER, M. D.,

Lecturer on Obstetrics in the College of Physicians and Surgeons, Baltimore.

History:—Before taking up the discussion of puerperal septicæmia, I will mention briefly a few of the epidemics and some of the theories that have been held in regard to it, that you may be the more impressed with the importance and fatality of the disease, than you might otherwise be, when you learn that you will rarely see it. The importance of the disease to you depends not so much upon its frequency as upon its fatality, and upon the fact that it is to a very great degree preventable.

Dr. Churchill, in his paper on the "Epidemics of Puerperal Fever," enumerates sixty-one epidemics that occurred in the one hundred years from 1746 to 1846. Hirsch mentions 216 epidemics, distributed as follows: in wards of lying-in hospitals, 129; in lying-in wards, and

*Saturday Lecture delivered at the College, April 19, 1890.

also among the general population, 41 ; in cities and districts, but not in hospitals, 34 ; scattered, 12. Dr. Churchill states that the first undoubted epidemic occurred at the Hôtel Dieu, Paris, in 1746. Of twenty women confined during the month of February of that year, scarcely one recovered.

In Westminster Hospital, between November, 1769, and May, 1770, out of sixty-three patients delivered, nineteen had child-bed fever and fourteen died.

An epidemic that occurred in the Royal Infirmary, of Edinburgh, in 1773, is thus spoken of by Prof. Young : "It began about the end of February, when almost every woman, as soon as she was delivered, or perhaps twenty-four hours afterward, was seized with it ; and all of them died, although every method was used to cure the disorder. The disease did not exist in the town !

Dr. Lobott, master of the Dublin Lying-in Hospital from 1814 to 1821, states in his report to the Board of Governors, dated February 4, 1820, that during the years 1815-16-17 the hospital was healthy ; of nearly 10,000 women admitted, there was a mortality of but one in 151 : in 1818 the mortality was one in 62. In September, 1819, puerperal fever made its appearance, and that, "from the first of September to the thirty-first of December, of 1,010 admitted, 129 took the fever and 61 died." And from the first to the thirty-first of the following month, of 171 patients admitted, 60 there were attacked and 25 died.

Hippocrates and Avicenna were familiar with the disease and thought it due to the suppression of the lochia. This theory was held by Sylvius, Strother, Smellie, and many other eminent physicians. Metastasis of the milk has also been thought the cause of the disease. Eismann states that it was assumed by the advocates of this theory that there might be a lacteal pneumonia or pleurisy, lacteal apoplexy, lacteal mania, or a lacteal anything that a fertile imagination could invent. Winckel says that Romel

even went so far as to assert that he had made butter out of milk that had been discharged from the intestine. The biliary theory was of later origin and was taught by many eminent German and English authorities who supposed that puerperal fever was originated by the biliary matter and mucus accumulating in the intestinal canal during pregnancy. Other observers believed that the main factor in the causation of the disease was an inflammation of the uterus, intestines or peritoneum.

CASE No. 1105, white, primipara. The labor was normal. There were slight lacerations of the cervix and perineum. The evening of the day on which she was confined her pulse was 108, temperature 101°. The next morning her pulse was 120, and temperature 99.5° ; that evening the pulse was 112, temperature 90°. Later in the evening the pain, tenderness and distension of the abdomen indicative of peritonitis came on rapidly. The low temperature at 7 P. M. was due to the antipyrine that had been given. The third day, both morning and evening, the pulse was 128 ; the morning temperature 99.5° and in the evening it was 108°. The fourth day the morning pulse was 140, temperature 101° ; the evening pulse was 156 and temperature 103°. She died at 11.30 P. M. Just before death the temperature was up to 107°.

She was given antiseptic vaginal injections to correct an offensive discharge. An occasional dose of antipyrine was given to reduce the temperature, but when the temperature fell, the pulse did not decrease correspondingly. After the symptoms of peritonitis developed, she was given morphine in sufficient quantity to relieve the intense pain, and to reduce the respiration to ten or twelve to the minute.

CASE No. 1088, white, confined with fifth child about 9 P. M. 1st stage 18 hours. 2nd, stage one hour. Labor normal. The next morning the pulse was 100, temperature 101° ; that evening pulse 104, temperature 102.5°. The

uterus was rather large, but firm, and slightly tender on pressure.

The second day after labor the pulse had risen to 120, the temperature to 103.5° . The area of tenderness had increased. From this time on, the area of tenderness increased, till it included the whole abdomen, which at the same time became much distended. The uterus remained contracted: there was no offensive lochial discharge: the pulse at all times was very feeble; the mind was clear. Antipyretics would reduce the temperature only temporarily, but did not affect the pulse rate. Opium was given to relieve the pain.

Until the morning of the seventh day after confinement, the pulse varied from 112 to 128, the temperature from 101.5° to 103.5° , the latter being the highest recorded temperature up to this time. The evening of the seventh day, the pulse was 160, the temperature was 105° . She died at 10 P. M., just one hour more than a week from the time of delivery.

Immediate Causes.—Septicæmia is an infectious disease, *i.e.*, "a disease which is caused by an invasion and reproduction within the body of pathogenic micro-organisms" (Welch).

The earlier observers lost much time and caused not a little confusion by not differentiating the organs of putrefaction which are comparatively harmless when inoculated into the body, from these micro-organisms, which, when introduced into the body, multiply there and produce septicæmia, or other infectious disease, as the case may be.

One of the first to direct attention to this field was Mayerhofer. In 1865, he found that the lochia of infected women contained micro-organisms, which he considered the cause of the decomposition. In 1869, Coze and Felz found in the blood of patients suffering with puerperal septicæmia, "round corpuscles, arranged in the form of chains." Afterward Rindfleisch mentions having found micro-organisms in the muscular structures of the heart. These observers have

been followed by Recklinghausen, Waldeyer, Orth, Klebs, Wolff, Pasteur, Ehrlich, Fränkel, Carl Lomer and others. There is no mention of any of these observers failing to find the chain-like micrococcus; all succeeded.

Coze and Felz injected hypodermically the blood from septicæmic patients into rabbits. A majority of the rabbits died of diarrhoea and convulsions. If the blood of one of the infected animals was used, the same symptoms were noticed. In this blood was found the chain-like micrococcus.

Eberth and Orth both inoculated the cornea of rabbits with material obtained from puerperal septicæmic patients, and found, upon examination microscopically, the chain-like micrococci.

There is no method as yet known by which the chain-like micrococcus of puerperal septicæmia can be distinguished from similar micro-organisms found in scarlatina, diphtheria and erysipelas. But this fact argues rather that the present methods of investigation are defective, than an identity of the micro-organisms.

Carl Lomer, of Berlin, in writing of "The Relations of Micro-organisms to Puerperal Fever," gives the following recapitulation:

"I. The chain-like micrococci have frequently been found both in the exudations and in the organs of patients having died of puerperal fever.

II. All observers have noticed the same characteristic variety.

III. Different species have hitherto never been discovered.

IV. It seems as though all who sought for them have been able to find them in every case.

V. More recent researches have shown that, besides the chain-like micrococcus, other micro-organisms—*i. e.*, bacteria—can be found in puerperal fever.

How these micro-organisms produce the symptoms which accompany their presence, is an interesting question. It is extremely probable that of themselves they do no harm, but that it is through

certain poisonous compounds generated by them that they produce the symptoms. After they are once within the body, their action is in all probability much the same as that of the micro-organisms of some other infectious disease which have been carefully studied.

For example, by the cultivation of Koch-Eberth's typhoid bacillus on beef-broth from eight to fourteen days, at a temperature of 37.5° to 38° (C), Brieger obtained typhotoxine C₇H₁₇NO₂. When typhotoxine is injected into a mouse or guinea-pig, there is at first salivation and increased respiration; then the salivation increases, the heart and respiration become weaker, the animal has diarrhoea, the pupils dilate, and the animal dies in one or two days.

Tetanine C₁₃H₃₆N₂O₄, is a similar substance. Brieger has obtained it by cultivating the impure tetanus microbes of Rosenbach in beef-broth. More recently Brieger succeeded in obtaining tetanine from the amputated arm of a patient suffering from tetanus, the physiological and chemical reactions of which were identical with those of the compound formed by the cultivation of the microbes in beef-broth. This base, when injected into animals, produces all the characteristic symptoms of tetanus.

While it has not been demonstrated, it is probable that the chain-like micrococcus of septicæmia produces basic substances similar to those shown to be produced by the typhoid bacillus and the microbe of tetanus, and it is really these basic substances that directly produce the symptoms.

As to what becomes of the micro-organisms in the cases that recover, or by what means or in what condition they are eliminated from the body, we know nothing positive. We know that in certain infectious diseases, the pathogenic micro-organisms are in some way destroyed by the living tissues, and there is no doubt but that the living tissues have power to destroy certain numbers of the micro-cocci of septicæmia. Welch, in speaking of the "Modes of Infection," makes the follow-

ing statement:—"The specific germs of infectious diseases can, and in cases of recovery, doubtless often are, destroyed within the body. Contrary to what many have believed, the kidneys and the intestines cannot be regarded as important means of freeing the body from micro-organisms that have gained access to the blood. When specific micro-organisms of an infectious disease are found in the urine or in the feces, it may be inferred that the genito-urinary apparatus and the alimentary tract respectively, are the seat of some lesion produced by these organisms."

Symptoms:—The first symptoms come on, as a rule, very soon after confinement; most often within twenty-four hours; more rarely, after forty-eight hours have elapsed. There may or may not be a chill. The first rise of temperature is usually not over 101° or 101.5°. Within the first few days the temperature may run to 102.5° or even 103.5°; the latter figure is very high. Just before death, or after there is set up a secondary sapremia, the temperature may run to 105°, or above that. The pulse from the beginning is rapid—120 to 160—and very small: the respiration is hurried. If the temperature is brought down by ordinary antipyretics the pulse does not fall accordingly. There is, quite early over the uterus, more or less tenderness, which extends as the disease progresses. The uterus may be quite large but firm; the abdomen becomes tympanitic and tender; the extremities are cold; the mind clear. The lochial discharge in many cases is apparently little changed or suppressed. In some cases the lochia may be decomposing, but not as a rule. The face is pinched and has an anxious expression.

Contagiousness:—The evidence of the communicability of this disease is so voluminous, and the number of series of cases so great, that I shall not attempt to do more than quote some of the opinions and evidence presented by a few of the numerous writers on this subject.

Mr. Roberton of Manchester, states,

that between the 3rd of December, 1830, and the 4th of January, 1831, a midwife attended thirty patients of a public charity, sixteen of whom had puerperal fever and all died. Other midwives from the same institution attended 380 women during the same time, and had no cases of puerperal fever.

Dr. Gooch states that a "practitioner opened the body of a woman who had died of puerperal fever, and continued to wear the same clothes. A lady whom he attended a few days after was attacked with, and died of the same disease : two more of his lying-in patients, in rapid succession met with the same fate. Struck with the thought that he might have carried the contagion in his clothes, he instantly changed them and met with no more cases of the kind."

Dr. Campbell writes, "In October 1821, I assisted at the dissection of a woman who had died of the disease, after an abortion of the early months ; the pelvic viscera were removed and I carried them in my pocket to class-room. The same evening, without changing my clothes, I attended the delivery of a poor woman in Canongate ; she died. Next morning I went with the same clothes on to assist some of my pupils who were engaged with a woman at Bridewell, whom I delivered with forceps ; she died. In 1820 I assisted some of my pupils at the dissection of a patient who died of the disease. For want of accommodation I was unable to wash my hands with the care I ought to have done ; on arrival home, finding that two patients required assistance, I went to them without further attention of my hands or changing my clothes, and both of them were seized with the disease and died."

Dr. Gordon, who was the physician to Aberdeen Dispensary from 1785 to 1795 gives some of the most positive evidence of the contagiousness of puerperal septi-cæmia in a treatise on that subject, he says : "It prevailed principally among the lower classes of women ; but women in the high walks of life were not exempt if they happened to be delivered by a

midwife or physician who had previously attended any patients labouring under the disease." "I plainly perceived the channel by which it was propagated ; and I arrived at that certainty in the matter, that I could venture to foretell what women would be affected by the disease, upon hearing by what midwife they were to be delivered, or by what nurse they were to be attended during their lying-in ; and, in almost every instance my prediction was verified."

He gives a table of seventy-seven cases of these he says : "The midwife who delivered No. 3, carried the infection to No. 4, from No. 24 to Nos. 25, 26, and successively to every woman whom she delivered. The same thing is true of many others, too tedious to be enumerated. It is a disagreeable declaration for me to (make, that I, myself was the means of carrying the infection to a great number) of women.

"The midwives of Aberdeen carried the infection to the Printfield great cotton-works, two miles from town, where a great number of lying-in women were affected ; while at the same time, the women in the neighborhood who were delivered by county midwives escaped. In short, I had evident proofs of its contagious nature, and that the contagion was as readily communicated as that of the small-pox or measles, and operated more speedily than any other contagion with which I am acquainted."

(To be continued.)

Society Reports.

MEDICAL AND SURGICAL SOCIETY OF BALTIMORE.

STATED MEETING, HELD DEC. 26TH, 1889.

The 703rd regular meeting of the Society was called to order by the President, Dr. R. W. Mansfield.

Dr. D. W. Cathell reported several cases of

POISONING BY NARCOTICS.

CASE 1.—Male, æt. 26, took 3 iss of laudanum, about 7 P. M. In an hour and a half or two hours thereafter he was discovered in a comatose condition.

The treatment in this case consisted in flicking with wet towels, enemas of strong coffee, and enforced exercise. Up to 12 P. M., it was thought he was doing well, when symptoms of heart failure developed. The faradic current was used with good effect. At 5 A. M., the patient arose to urinate, when he suddenly fell. Remedies were applied and he rallied. At 7 A. M., he was thought to be so well on the way to recovery that the doctors left him, agreeing to meet again in an hour, but shortly after the doctors left he died suddenly from heart failure.

CASE 2.—A man who had taken 3 i of laudanum about 7 P. M. About 9 P. M., the doctor arrived with a stomach pump. The patient was still conscious and threatened the life of any one who dared touch him. Under these circumstances it was decided to wait until he became comatose. At 9.30 four men seized him and he was put under the influence of chloroform. Several times, the stomach was pumped full of strong coffee and evacuated; the last time, the stomach was left full of coffee. Enemas of coffee and the usual adjuvants were used. He recovered.

CASE 3.—A woman, æt. 25, who said she had taken three bottles of laudanum. On the doctor's arrival, he found her ascending the stairs to her room in the third story. A strong odor of opium was noticed in going up-stairs, but on gaining her room, the character of the atmosphere was entirely changed; there was no odor of opium whatever. She made an effort to simulate the symptoms of opium poisoning, but it was soon apparent that it was not a case of poisoning. This case was mentioned, as showing the importance of being on one's guard.

CASE 4.—A man æt. 35, having had some disagreement with his wife, took 3 ii of laudanum about 9 P. M. He was discovered at 5 A. M., in a critical condition; he was cyanotic, bathed in a cold perspiration, stertorous breathing, with no pulse at the wrist. Dr. Cathell said he decided to use atropia in this case as suggested in Dr. Dunglison's Practitioners' Reference Book. A solution of atropia sulph. gr. i to 3 ii of water, was used, each minim representing 1-120 of a grain. Fifteen minimis, or gr. $\frac{1}{8}$ was inserted in each arm, and in twenty minutes the pupils were dilating. The usual adjuvants of coffee by enema &c. were used. In two and a half hours he was very much better. By 12 o'clock he was out of danger, though suffering with an intense headache. The next day he was discharged.

CASE 5.—A boy who drank about 3 ii of laudanum; he was comatose when first seen; he was treated with subcutaneous injections of atropia with good result.

CASE 6.—Woman æt. 35, weight about 130 pounds. She had taken 3 iss of laudanum. When first seen she was in a profound coma. It was impossible to arouse her. The finger could be placed on the cornea without exciting any reflex whatever. Three minimis of the solution of atropia, for each grain of opium that had been taken, half in each arm were injected subcutaneously. In half an hour her pupils were dilated. At 7 P. M. she was out of danger. She had taken the poison about 4.30 A. M. Coffee and the usual adjuvants were used in this case. She made a good recovery.

CASE 7.—A man who was suffering from a gastralgia, had been ordered a solution of morph. sulph. containing gr. ii by the physician in attendance. The nurse had been directed to give such quantity as would represent gr. $\frac{1}{8}$ every half hour *until relieved*. The nurse misunderstood the directions and gave the medicine until it was all used, even arousing the patient to administer it. He was comatose all night and when seen at 7 A. M.,

his physician was in doubt as to whether his symptoms were caused by the morphine and ordered spts. ammon. aromat. But in the afternoon there were more decided symptoms of morphia poisoning. At 7 P. M., Dr. Cathell was called to see the case. He went to his office for his hypodermic syringe, but when he got back to the patient, he learned he had suddenly died on making an effort to urinate. He was certain the patient could have been saved, had his condition been recognized at 9 A. M. He thought it of importance to learn the quantity of opium that might be taken in a case, so as to regulate the dose of the antidote.

Dr. David Streett said he had not had such success with atropia. If the quantity be small, the atropia might prove efficacious, but he did not think it reliable when large doses had been taken. He thought that the faradic current, strong coffee and flagellation, as good as any other treatment.

Dr. H. T. Reynolds said he had considerable confidence in atropia as an antidote to morphia. He had given it to the exclusion of all other remedies in some cases, with good result. He staid by his patient, watched the pupil and gave the atropia as indicated. He had pressed it as much as gr. $\frac{1}{2}$ in the hour. As a rule he used atropia, coffee and faradic electricity. The age of the patient should be taken into account. He once saw a child at 3, who had swallowed a collyrium that contained about gr. jss of atropia. He saw the child about two hours afterward and he saw no effects from the atropia then, and the patient did not develop any symptoms whatever from the dose.

Dr. S. T. Earle suggested that in heart failure in opium narcosis, a heart stimulant, such as strophanthus might be used with benefit.

Dr. Wm. H. Norris said he did not think the old method of administering and pumping out the stomach with strong coffee should be neglected. He thought it almost impossible to ascertain exactly the amount of opium that was taken in

a given case, as druggists usually keep two strengths of laudanum, one for prescriptions, and another, much weaker, for retailing over the counter,

Dr. Chas. B. Ziegler said he used atropia as an antidote in opium narcosis about twelve years ago, and had occasion to use it again about three years ago. In both cases it acted well. He thought that many patients had died from over-stimulation by the atropia, and had died from the substitution of atropia poisoning for opium poisoning.

J. WM. FUNCK M. D.,
1710 West Fayette Street.

CLINICAL SOCIETY OF MARYLAND.

STATED MEETING, HELD FEB. 21ST, 1890.

The 239th meeting of the Clinical Society of Maryland was called to order by the President, Dr. Robert Morison, in the chair.

Drs. Feddeeman, Woodbery, Amanda Taylor Norris, Harlem and Fremont Avenues, and Joseph A. Wright, Pikesville, Md., were elected members of the Society.

Dr. L. McLane Tiffany exhibited a patient on whom he had operated for

BILATERAL SUPPURATIVE NEPHRITIS.

Patient: white, male, aged 32 years. In March, 1889, while at business, he experienced discomfort in the right side, which gradually developed into intense pain. This was accompanied by loss of appetite, and he had a chill daily; fever and sweating were noticed after the chill. Pains in the loins then came on, and the thigh became flexed on the pelvis. On May 12th, patient found a lump in his groin about the size of a hen's egg. Prior to this attack, he thought he had a stricture and in consequence of this, applied to a physician for treatment. A soft sound was used and passed without

difficulty, but the introduction of a steel sound brought on intense contraction of the urethra, and it would not enter it. Soft sounds were passed twice a week for two or three months. On May 15th the patient came to Baltimore, and he saw him that night. Fever, dry tongue, etc., marked his condition at that time. On May 16th, he was examined, and a tumor found over the region of the left kidney : Fluctuation was evident. There has been made in Chicago a diagnosis of malignant disease of the kidney. On May 20th patient was operated on : the left loin was opened with the usual incision, the kidney was found, and quite a pint of pus was evacuated ; the wound was thoroughly washed out and dressing applied. After the operation, agonizing pains came on, and extending into the thigh, requiring much anodyne to relieve it. The wound was kept clean, and the patient did well. As soon as he was able he was sent to Oakland, Md., and there he improved very rapidly. In September he could walk a mile and ride all day.

Awhile after this he thought he strained his right side, but it was thought by those who saw him to be more serious. In October, a lump made its appearance. He returned to Baltimore in November, and was examined and operated on by Dr. Tiffany. The lump above referred to was found to be freely movable and was seen to move up and down during respiration. The peri-nephritic tissue was all right. He then cut into the kidney and evacuated $1\frac{1}{2}$ ounces of pus. Patient soon recovered from the effects of the operation and rapidly improved in condition. No urine flowed from the wound in either case. In the second operation the kidney was seen, handled, cut into and pus evacuated. The other kidney probably acted in the same way in its beginning, and he concludes that he had to do with a case of alternating suppurative nephritis. It was probably brought about by the use of dirty instruments : the only other cause to which it could be referred is the uncertain con-

dition of reflex action, but this may have been the exciting cause. The fact of the contraction of the urethra when the use of the steel sound was attempted should be kept in mind. Pus was in the urine during the time of the suffering, and some of it still remains.

Dr. John W. Chambers said he wished to relate the history of a case that had some bearing on the subject presented by Dr. Tiffany.

Patient was a lady, aged 35 years, whose health previous to the attack was good. About five years ago she had a lump to appear in the left lumbar region. This was rubbed with some lotions, and disappeared, according to her own statement. In December last, a lump began to grow in her left side. He saw the patient in January, and found a tumor in the region above referred to, about the size of a baby's head. It was very movable, and from the evidence on examination it was thought to be an abscess of the kidney. Some pus was drawn from it, and the patient then declined further interference. After three weeks had passed he saw her again, however, and the kidney was cut down on ; 165 ounces of pus were evacuated. Awhile after the operation she died, and the autopsy showed the kidney to be a regular pus sac. He believes that this was a case of hydronephrosis in the beginning. No pus was found in the urine at any time ; the valve-like arrangement of the ureters at the kidneys must have prevented its flow by the pressure brought to bear from the large accumulation of pus. The other kidney was healthy, but about one-third larger than it normally ought to have been. This indicates that the lesion in the other kidney was of no recent date.

Dr. George J. Preston read an interesting paper on

THE PERSISTENT IDEA OF HEREDITARY TAINT.

Dr. I. E. Atkinson said that he was very much interested in the subject

brought to our notice by Dr. Preston, and recognizes the force of his argument in combatting the persistent idea. The difficulty is just how far we can do this. So pronounced is the influence of heredity that breeders of animals can do almost as they wish in producing certain types of offspring. That morbid heredity is not so persistent amongst us is due to the mingling together of individuals. Individuals born of insane patients, or of parents with acquired disease, no doubt will be influenced by the law of heredity. The difficulty in coming to Dr. Preston's conclusion is, how far we can conscientiously prevent this idea.

Dr. Thos. S. Latimer said there is one fact to be borne in mind in studying the law of inheritance in the lower animals, and that is: their lives vary but little. In human beings there is a more general scope. Their environments are many and numerous, and no doubt these and physical causes are important factors in developing heredity. By properly appreciating these factors, many of the mental anticipations may be relieved and many consequences avoided.

Dr. C. G. Hill said there is no doubt but that there is exhibited a tendency to develop certain diseases, and related numerous instances in proof of this point. Much good can be done by keeping this fact in mind and advising our patients accordingly.

Dr. Joseph T. Smith said the practical outcome of the law of heredity amounts to very little. We have no control over begetting of offspring. Environments are in the parents and the children are bound to be influenced by the same causes.

Dr. George J. Preston said the subject had taken a much wider range than he had intended. As to the general law of heredity, no one will doubt. The question of acquired peculiarity is not settled, but facts are constantly being collected on that point.

The point that he wanted to make was the psychical side of the subject. Environment is a very important factor to keep in mind.

In such conditions, hypnotism has been employed to suggest ideas. Under its influence some cases have improved, some have not.

Dr. J. G. Wiltshire reported

A CASE OF HARE-LIP

on which he had operated.

W. J. JONES, M. D.,
Recording Secretary.
1238 Greenmount Avenue.

The Faculty of the University of Maryland proposes to make some improvements and additions to the University Hospital this summer. The chapel building will be extended to the alley in the rear of the hospital which will make an addition of 102 by 35 feet, a large proportion of which will be devoted to the accommodation of the training school for nurses, a part of it for the domestic service, a new immigrant ward and some isolating rooms. The front of the hospital will be repainted and reglazed, large panes being inserted instead of the small ones. The kitchen will be modified so as to be taken in the house proper and placed in an annex in the back yard. The private rooms will be refurnished and provided with electric bells.

The regular work of the training school has begun. Lectures are being delivered by members of the Faculty on various subjects pertaining to the course and probationers also receive practical instruction by the superintendent, Miss Parsons.

The Superior Court at Boston has found for defendant in the case of Mary O'Brien vs. the Cunard Steamship Company, a suit for \$10,000 for alleged damages to health arising from compulsory vaccination.

In the programme of the American Medical Association, are found the following from Baltimore, who will read papers at Nashville: Drs. Geo. H. Rohé, H. A. Kelly, G. M. Sternberg, T. B. Evans and J. J. Chisolm.

MARYLAND MEDICAL JOURNAL

Weekly Journal of Medicine and Surgery,

WILLIAM B. CANFIELD, A.M., M.D., Editor

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BALTIMORE, MAY 10, 1890.

**THE MEDICAL BILL SACRIFICED
BY THE GOVERNOR.**

Governor Jackson has permitted the constitutional time allowed for signing bills passed by the General Assembly to go by without giving his signature to the Medical Bill. The bill, therefore, fails to become a law. The profession and the people of Maryland are left for another period of two years without protection from the annual invasion of medical quacks and incompetent practitioners squeezed out of other States into this State. His excellency has shown a spirit of narrow-mindedness and of prejudice utterly unworthy of a cultivated and enlightened Executive. He has treated the medical profession of Maryland with the most marked disrespect and disregard. He has shown the fact, that a dozen or

less physicians who hold official positions under his party, have more influence with him than the opinions and wishes of hundreds of medical men in this State who bear the burdens and responsibilities of active professional work. Evidence in abundance has been presented to him to show the justice and fairness of the Medical Bill, and the necessity of such a law as it provided for.

There is no excuse in reason or justice for his action, and the medical profession of Maryland has the right to hold him responsible at the bar of professional opinion for his conduct. We are well aware of the fact that his Excellency has no regard for such opinions, and that he cares but little for the criticisms which may be poured upon him. He may be too far advanced in life to desire further political honors, and perhaps feels indifferent to the opinions of a large class of citizens who can exercise a strong political influence. We have reason to hope and to feel assured of the fact that his Excellency's official life will terminate with his present term of office. What we have now to say will, therefore, hardly apply to our present Governor, but it should have a strong bearing upon his successor.

The facts of the case may be briefly stated. The medical profession of Maryland has a grievance; it has been positively insulted by the Governor of this State. It has no redress so far as he is concerned, except that expressions of disgust and indignation which every citizen must feel for the weakness and bitterness of a man, who has been elevated to a high position of honor and trust and who has boldly disappointed the men who helped to do him this honor. The writer of this article gave his vote to the

present Governor of Maryland. He now humbly apologizes for his inconsiderate act.

To come to the point. The action of the governor in relation to the Medical bill, teaches the profession of Maryland the urgent need of professional organization and coöperation. The physicians of this State have rights which should be respected. Such rights will not be respected unless the profession of this State asserts them and organizes to protect them. Attempts have been made for years past to obtain a medical law in this State. Why such attempts have failed, we have not the time here to discuss. The present Medical Bill passed by the General Assembly of 1890, was the nearest approach to a medical law which has yet been made. It gives the profession, and the citizens of Maryland the legal protection needed, and a law almost identical with that in force in other States, which experience has shown to be highly beneficial to both classes. The bill was killed by the Governor through an influence which the profession of this State has heretofore sustained. The Governor's confidential adviser has stated that the influence which destroyed the Bill, originated with certain members of the State Board of Health. Whether this fact be true or not the profession of this State should act advisedly in the matter. Let the State Board of Health individually exonerate themselves of this charge if they desire to do so. The burden of proof is with them. It is currently reported and believed that the opposition originated with members of this Board, and their members are held by the profession of Maryland as the responsible agents in the matter. This is the common talk in professional circles.

If it is an unjust attack upon the Board of Health, let the Board as individuals repudiate it. We make no direct charge but we are prepared to make public the evidence upon which the charge is based.

The medical profession of Maryland must make its own investigations and then act intelligently. We say it boldly that this Medical Bill was defeated in defiance of the great preponderance of professional opinions in this State. A similar attack will again be made upon any medical bill presented to the General Assembly of Maryland, and to the Governor of Maryland, which does not recognize the political element in the profession in Maryland. The Medical Bill of 1890 asked for no State appropriation; it made no provision for a political incumbent; it gave the medical politician no place in its execution, but vested its authority in the hands of the medical profession of the State regardless of party. These facts account for its defect. The Bill was not popular for these reasons and upon these hypothesis alone can its fate be accounted for.

How is the profession of this State to obtain redress? We answer, by organization, by the exercise of its influence individually and combined, by the authority of its claims upon the people of the State with whom it is thrown into the closest personal and most responsible relations.

No class of professional men comes nearer the voter than the physician. If this fact is kept in view and acted upon, the next Legislature and Governor of Maryland will stand committed to a Medical Law which will command respect and consideration. We urge the physicians of Maryland to consider these facts and to act accordingly.

Correspondence.**THE NOTIFICATION OF CONTAGIOUS DISEASES.**

Baltimore, May 6th, 1890.

Editor Maryland Medical Journal:

DEAR SIR:—The letter of Dr. Robert T. Wilson's, and your editorial on same of April 26th on "The Notification of Contagious Diseases" lead me, with my experience, to ask, of what use are the "Sanitary Inspectors?" In my experience they do no good and in Dr. Wilson's case they positively do harm.

I will relate, as examples, two cases from many: one that happened just before the present Health Commissioner went in and one since. In January, I reported a case of scarlet fever. I gave the person's *name, age and address*, all of which are required. The Sanitary Inspector called, asked the *name and age* of patient, then he asked if everything was clean about the house. (Everything was clean, but he had no cause for believing so from the entrance and appearance of person answering the door.) She told him yes, except the out-closet was running over into the neighbor's yard, and that she could not get the landlord to attend to it. He did not look to see if it was so, but said he would have it attended to, and she has never heard from the "Health Department" since.

Recently, I reported a case of measles. The Sanitary Inspector has yet to call and stop seven other children, going to three different schools, from attending school.

Now, please let the Health Department tell us what we have to report these cases for; to publish every week in the newspapers that there are over 200 cases of measles in the city to frighten all the timid mothers? Or do we have to report them so that an *intelligent* health officer may call and by stopping the children from school and keeping them, as far as warning the parent will permit, from

mingling on the street with other children until the danger of infection has passed? In both of these cases I speak of the mothers, who, though ignorant of the laws of health, knew more than the *regular appointed Sanitary Inspector* who called to see them, for, before I was called in, they had isolated the sick one and stopped the rest of the children from school. Now, why does not the Health Department take the advice of the commissioners recently appointed by the Mayor to investigate affairs in the City Hall? They advised that these places be filled by physicians. The physicians report everything that the Sanitary Inspector finds out or does, as he is now constituted, and I am told that the rest of his work consists in going to look at an alley that has a dead cat in or is in a bad condition, when *somebody else* reports it. He goes—he looks—finds the cat, and then, with all the dignity due his office, instructs the police to tell the right party to have it attended to.

So, Mr. Editor, please find out for me if this officer has any other duties, and if not, then answer the question in the first part of my letter.

Yours truly,

L.

Medical Items.

The daily papers announce the death of Dr. Samuel Rush Haven, of Chicago.

A woman in this city gave birth to triplets recently.

Dr. James L. McCormick, formerly of Baltimore, has opened an office at Trappe, Talbot county, Md.

Dr. Yung Do King, the well known New York Chinese physician, died last week.

Dr. Wm. N. Martin, a graduate of the University of Maryland, class of 1850, died in Westminster last Tuesday.

Dr. William R. Wilmer, formerly Naval Officer of the port of Baltimore, died April 25.

As the result of profession quarrels, St. Louis will have a new medical school called the Marion-Sims Medical College.

A ten-story building, with elevators, is about to be erected in Pittsburgh for physicians' offices.

Dr. Rosa Kerschbaumer is the first woman licensed to practise medicine in Austria. She is said to be an uncommonly able oculist.

By the will of the late George S. Pepper, the University of Pennsylvania gets \$60,000 for the endowment of a professorship.

Dr. J. W. McSherry, a prominent physician of Martinsburg, was nominated as Democratic candidate for Mayor of that city, last Tuesday.

Health Commissioner Rohé calls the attention of all schools, public and private, to the necessity of seeing that the children are properly vaccinated.

The Pharmacopœial Committee has been asked to use the metric system in the next issue of the United States Pharmacopœia. If this is done, the equivalent in the system now in use should be given in each case.

The Seventeenth National Conference of Charities and Corrections will meet on May 14 in Baltimore, and will continue in session until the 21st. The object of the conference is to obtain and diffuse information respecting benevolent, charitable, penal and reformatory work. Among the papers to be read will be one on "The Relation of Public Hospitals to the Medical Profession," by Dr. Henry M. Hurd, of the Johns Hopkins Hospital; one on "Training Schools for Nurses," by Miss I. A. Hampton, of

Johns Hopkins Hospital, and one on "Almshouse Abuses and Reforms," by Dr. C. W. Chancellor, of the State Board of Health. Dr. Richard Gundry, of the Spring Grove Insane Asylum, will submit the report of the committee on "Care of the Insane."

In order to hasten the opening of the Medical School of the Johns Hopkins University and to secure for women the most advanced medical education, it is proposed to raise the sum of \$200,000 to be offered to the Trustees on condition that women whose previous training has been equivalent to that of the preliminary medical course of the university, be admitted to the school, whenever it shall open, on the same terms as men. Energetic and well meaning women in this and other cities knowing that money is a key which unlocks most doors, have already subscribed a large sum and it is probable that the full amount will be very soon offered on the above condition to the trustees who will hardly have the courage to refuse so large a sum.

A petition was lately presented to the Medical Assembly of the Grand Duchy of Baden by the German Women's Association of Leipzig, praying that women might be admitted to study medicine. The Assembly passed a resolution declining to take any step in the matter, on the ground that women are unfit for the learned professions, and especially for that of medicine, and, moreover that the latter is already overcrowded. Herr Arnsberger, the Ministerial Councillor representing the Government, said the question was not yet ripe for solution. He also pointed out that the matter was one for the decision of the Imperial authorities, not for that of the individual States. A similar petition has recently been presented by the same Association to the Weimar Landtag, in which the ladies ask to be admitted to the University of Jena, not only to study medicine, but with the view of qualifying for appointments as scientific teachers.

MARYLAND MEDICAL JOURNAL,

VOL. XXIII. No. 3. BALTIMORE, MAY 17, 1890.

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HYDATID CYST OF THE LIVER (SUPPURATIVE). OPERATION, AND RECOVERY OF PATIENT.*

BY CHARLES F. BEVAN, M. D.,

Professor of Principles and Practice of Surgery,
and Clinical Surgery, College of Physicians
and Surgeons, Baltimore, Md.

[Being Chairman's report of the Section on
Surgery.]

A casual reading of the standard textbooks leaves one with the impression that hydatid cysts are rather of common occurrence. It is true none of the authorities express in figures or percentages the frequency with which the affection is encountered; and yet almost all alike speak of it as though the malady were an everyday affair. That the disease is of more frequent occurrence in some countries than in others there can be no doubt. In Iceland, Australia, and in some parts

of Germany, it seems to be met with rather frequently, while in this country it is of very rare occurrence. The examination of more than 300 bodies, personally conducted, failed to reveal a single example. The records of the College of Physicians and Surgeons' dissecting room, over 1,500 examinations and the post-mortem records of the City Hospital, 250 more, make no mention of the malady.

Osler, *Am. Jour. Med. Sci.*, Vol. 84, 1882, collected the records of 61 cases from museums, journals, transactions and private sources. He says, "Unfortunately we cannot say positively how many of these cases were truly American, i. e., originated here, and how many were imported, but in 16 it is stated that the patients were Europeans. In the majority the nationality was not given, but in all probability at least one-third of the cases were imported, leaving only about 40 cases."

The rarity of the affection and the satisfactory result of the treatment justify

*Read before the Medical and Chirurgical Faculty of Maryland at its 92nd Annual Session, April 23rd, 1890.

me in calling your attention, therefore, to the following case.

Case.—Fred. Bersenbrüch, a native of Oldenberg, Germany, 44 years of age; occupation, farmer; a resident of this country for the past eight years: was admitted to the City Hospital October 25th, 1889. He gave the following account of himself: Has been working on a farm, and for several months has been clearing the land of stones, many of which he carried for some distance, bearing the weight against his right side. In March of 1889, he was seized suddenly with pain in the right side, back of the abdomen and chest. This pain, at first acute, subsided in a few days, without treatment. In May, a swelling was noticed by him in the right hypochondriac region, which has since increased in size and become painful on pressure. From this time on to the date of his admission to the hospital, there has been a slow but progressive loss of weight, until now he is more than 40 pounds below his average weight. Disturbance of the digestive organs, vomiting, constipation, diarrhoea and dysentery, he reports as being of frequent occurrence. In July, he was taken with chills and fever, and was confined to bed for two weeks.

Examination showed a tall, cadaveric looking man, of sallow complexion, much emaciated and great feebleness. Digestive organs in fair condition. Kidneys good; pulse 80; respiration 28, shallow, coarse and fine mucous rales over both lungs; temperature 97° F.; weight 125 pounds; abdomen much enlarged—a tumor apparently of the liver, smooth, elastic, with an obscure sense of fluctuation. The following measurements will give some idea of the alteration:

I. Level of the 6th rib (in front): right side, 19 inches; left, $17\frac{1}{2}$ inches.

II. Level with apex of ensiform cartilage: right, $20\frac{1}{4}$; left, 18 inches.

III. Level with a point midway between ensiform cartilage and umbilicus. Right side, $19\frac{3}{4}$ inches; left, $16\frac{1}{4}$ inches.

Dullness extends to the right nipple above, and below to within 1 inch of a horizontal line drawn through the umbilicus. In the median line, dullness extends below to within $1\frac{1}{4}$ inches of the umbilicus, and from the point upwards $3\frac{1}{4}$ inches. The area of dullness does not reach the left mammary line. The ribs are much bulged out. The swelling transmits the voice on auscultation, and vocal fremitus is clearly felt on palpation. A slight pleuritic friction sound is made out at the upper limit of the tumor on the right side. A hypodermic needle was plunged into the most prominent part of the tumor, and through it a few drops of pus were withdrawn.

October 26th, had a chill; temperature 102° F., pulse 120

October 27th, temperature, 8.30 A.M., 98° F. 3 P.M., slight chill; temperature 103° F.

From this date to the time of operation the morning temperature would be slightly above normal, 99° – 100° F., with a chill and evening rise of temperature to 102° – $103\frac{1}{2}$ F., the febrile condition lasting throughout the night.

On November 1st, 1889, under chloroform, with full antiseptic precaution, though done in the amphitheatre, the aspirator was introduced into the most prominent portion of the tumor. Only about one ounce of purulent matter was withdrawn, when the fluid was found to choke up the needle. This fluid, under the microscope, showed an abundance of the hooklets so characteristic of the echinococcus. An incision was now made some 3 or 4 inches long, to the right of the rectus muscle, obliquely downwards and outwards. When the peritoneum was reached it was found to be non-adherent to the liver. Accordingly, iodoform gauze was packed into the wound, absorbent cotton and a bandage applied, and the patient was put back in bed. Four days later, under chloroform, the dressings were removed. Satisfactory adhesions had been produced and an incision $3\frac{1}{2}$ inches long was made

into the liver and into the cyst, evacuating $1\frac{1}{2}$ gallons of purulent fluid. The fluid contained myriads of transparent globules, varying in size from a pea to that of a small orange. When the sack had been well emptied, I thoroughly scraped with my hand the whole interior of the cavity, which extended to the right as far as the posterior border of the liver, and to the left nearly as far as the end of the left lobe. The cavity was then thoroughly washed out with a hot bichloride solution 1-5000, a large drainage tube was inserted and the edges of the cyst were then stitched to the skin and the remainder of the wound closed up around the tube. The patient, more dead than alive, was then placed in bed, and surrounded by hot bottles, etc. Reaction occurred in a few hours. For three days the temperature remained normal, but it rose to 101° F. on the fourth day, at which time the dressings were removed, the cavity washed out with a warm carbolized solution, and the patient was redressed. The stitches were removed on the eighth and tenth days.

November 28th and 30th, the temperature reached 100° F., but fell at once to normal, on carefully washing the cavity. During December, his convalescence was rather slow, his digestive powers feeble and cough very troublesome. January 12th, 1890, he had an attack of the grippe, temperature reaching 104° F. and slowly dropping to 99° F. The attack decidedly aggravated the bronchial catarrh which had been so annoying, and by January 20th a circumscribed pneumonia of the lower part of the right lung was clearly made out. He was able to be out of bed by the first of February, and has slowly but steadily improved. The cavity has greatly diminished, and now holds less than half an ounce (3 drachms.) He has gained 21 pounds, walks everywhere he pleases, and is desirous of resuming his occupation on the farm.

History.—Hydatid disease has been more or less under observation from the earliest of medical times. Hippocrates

describes certain tumors, watery in character, which modern writers accept as referring to the echinococcus. "The echinococcus," says Heller, (Ziemssen, Cyclop., Vol. III, p. 557), "was, however, first recognized in 1766. In 1782, Pastor Gröze discovered that the scolices were tape-worm heads."

The relationship between the echinococcus hominis and the *tænia echinococcus* of the dog has been very extensively studied and proven by experiment. Küchenmeister, von Siebold, von Beneden and Leuckart, in 1852, have shown this in the most convincing manner.

The *tænia echinococcus* seems to be one of the parasites infecting the intestinal canal of the dog, and indeed of the whole genus canis, with great frequency.

The echinococcus, which is merely the larval state of the *tænia echinococcus*, is voided with the animal's dejecta, and falls upon the ground. It may find its way into running water, springs, etc., and from such a source obtain the easiest mode of access into the stomach; or, if deposited on vegetable matter, cabbage, lettuce, celery, etc., these foods, unless thoroughly cleansed, may become the carriers of the larva to the body.

When within the alimentary canal of man, the embryo begins a process of migration, and from the intestinal tract may wander to any part of the body. Every organ of the body, bones and muscles, has been recorded as invaded by them. By far the largest number of cases occur in the liver. Böcker (Dissert. inaug., Berlin, 1868), found the echinococcus 33 times amongst 4,760 dissections made at the Berlin Pathological Institute: 19 times in 3,042 males, 14 times in 1,718 females; and of these 33 cases, 27 were found in the liver alone, or in the liver and other organs together. The ductus communis choledochus is believed to afford the most direct and easiest route to the liver.

Pathology and Symptoms.—When the echinococcus reaches an organ it begins the process of development, and may ultimately attain very large proportions,

In those affecting the liver, the rapidity of growth depends somewhat on the depth at which they are situated. Rarely indeed are they found on the surface of the organ. Tait, whose operative experience is larger than that of any one else, makes the emphatic statement, that the cyst "is always embedded in the substance of the liver, and to reach the cyst considerable thickness of the liver tissue has generally to be gone through. The tissue of the cyst is in immediate contact with the liver tissue, which it excavates into a form and shape to suit itself"

(*Edinburgh Medical Journal*, 1889, p. 408). As with most other tumors the general direction of growth is toward that in which the resistance is least. The displacement of relations to neighboring organs is often extreme. The increase in size of the growth, while not rapid, is believed to be continuous. The tumor may spontaneously cease to grow, and retrograde changes take place, or by an external injury, as a blow on the abdomen, or by ulceration into a bile duct, the death of the parasite may be produced (*Pepper's System*, Vol. II, p. 1103).

Hydatid tumors of the liver are usually described as being smooth, of irregular outline or contour, and highly elastic. By palpation, the sign called hydatid purring, which is simply the transmission of an external impulse through the various large and small daughter cysts to the hand, may be elicited. This sign was not present in the case here reported, though carefully looked for. The purring or vibration has been considered as pathognomonic. I have noted, however, quite a number of instances in which observers call attention to the fact of its absence. The most important and satisfactory diagnostic sign may be obtained by the use of the aspirator and the discovery in the fluid withdrawn of the characteristic hooklets of the scolex. In fact, the aspirator is about the only really reliable method at our disposal for diagnostic purposes. Hydatid tumors of the liver give rise to no pathognomonic signs.

Their presence may be suspected in such cases as tend to enlarge in the direction of the diaphragm, when, by the ordinary methods, pleural effusions are excluded, and the enlargement is clearly referable to the liver; or when the growth extending downwards, enables the examiner to detect the presence of a smooth, elastic, irregular-shaped tumor, clearly connected with the liver. From hepatic abscess for practical purposes, differentiation is not required; but here, too, the employment of the aspirator will enable one to arrive at correct conclusions.

Treatment:—While various plans and divers drugs have, from time to time received commendation, it is highly probable that none have been of really curative power. Errors of judgment are just as numerous here as in most other diseases. The fact is very few cases of hydatid disease are recognized during life, because the cysts give rise to no pain or annoyance, and rarely to the interference with the function of the organ; hence most of our knowledge has been derived from pathological studies. Cure is known to have occurred, when by the process of ulceration an exit from the cyst has been provided either into the stomach, intestinal canal, pleura, or best of all into the integuments; and death too is reported when important blood-vessels have been opened, or when the general peritoneal cavity has been invaded.

The simplest mode of procedure has been to puncture with a trocar, evacuating the fluid; the improvement in this method due to the aspirator, has been followed by a corresponding increase in the number of reported cases. There is a reasonable doubt, however, whether the method has been so successful as the reports seem to indicate. The mere withdrawal of the fluid lessens the size of the cyst, reduces the effects of pressure upon surrounding parts, but does not diminish the reproductive power of the mother and daughter cysts left behind. Moreover, it has been frequently followed by suppuration in the cyst with a resulting sepsis; and in still other instances fatal

leakage into the general peritoneal cavity has occurred.

Electrolysis, as a method of cure has received some decided attention. In the Medico-Chirurgical Transactions of London 1871, Mr. C. Hilton Fagge and Mr. Arthur E. Durham, reported 8 cases successfully operated upon by the method. The procedure is not devoid of danger, however, since needles are introduced into the cyst, and leakage into the peritoneum with fatal results has followed. Dr. Murchison (Clinical Lectures on Diseases of the Liver,) reports 3 deaths in 46 cases tabulated due to paracentesis, but the deaths which result from suppuration induced by the operative procedure, or from peritonitis are not enumerated. The most satisfactory results have occurred from more elaborate surgical procedures, made possible by the modern method of wound treatment. The earliest record of operative work upon the liver, is the celebrated case of cholecystotomy done by, I am proud to say, that very distinguished American surgeon, the late J. Marion Sims, in 1878. The operation was, however, suggested as possible by Jean Louis Petit. In this case the gall-bladder, greatly distended, contained many gall-stones, and the physical condition of the patient was such as to make the operation truly a last resort. Sims, having cut down upon the distended bladder, opened it, emptied it, and stitched its edges to the integument. His patient lived 8 days. After relating the post mortem condition, Sims sums up the lesson derived from this case in the following language: "In dropsy of the gall-bladder, in hydatid tumors of the liver, and in gall-stones, we should not wait till the patient's strength is exhausted, nor till the blood becomes bile-poisoned, producing haemorrhage; but we should make an early exploratory incision, ascertain the true nature of the disease, and then carry out the surgical treatment that the necessities of the case may demand."

This advice of Sims' bore fruit at an early period. In August 1879, Mr.

Lawson Tait, F. R. C. S., LL. D., etc., successfully carried out the brilliant proposal of Petit and Sims, by operating for the removal of gall-stones, opening the gall-bladder and stitching its edges to the integument. In the *Edinburgh Medical Journal*, volume XXXV, 1889, 305-401, Mr. Tait reports 55 cholecystotomies with 52 recoveries; 17 cases of hepatoxy 11 of which were for hydatid cyst, with 15 recoveries, and 17 cases in which an exploratory incision was made for diagnostic purposes, with 16 recoveries.

Mr. McEddowes reports a case of cyst of the liver, operated upon by incision, stitching edge of cyst to integument, followed by drainage and recovery. (*British Medical Journal*, 1884. Volume 1, p. 410).

Mr. E. Atkinson, (*British Medical Journal*, 1885, volume II, p. 873,) reports a case of cyst of the liver, treated by incision; edge of cyst stitched to the peritoneum and integument. Patient recovered.

Mr. E. H. May, (*British Medical Journal*, 1886, volume II, p. 17,) reports a case of hydatid cyst of liver. Peritoneum when reached was found non-adherent to liver; the wound was packed with carbolized gauze, and five days later adhesion having occurred, the incision was prolonged, liver and cyst incised, edges stitched to integument, drainage and subsequent washings resorted to. Patient recovered. Mr. May, relating the case says his patient, a lady, was especially fond of dogs, and had a pet lap-dog constantly about her. He wisely makes no further comments.

Mr. Wm. H. Bull, F. R. C. S., Edinburgh (*London Lancet*, volume II, 1888) reports a case operated upon by abdominal section October 9, 1887 under the impression of its being an omental tumor; when abdomen was opened, he found a hydatid cyst of the right tube of the liver. This was incised, stitched to integument, and drained. Recovery followed.

Mr. Henry Morris, (*London Lancet* volume I, 1889,) reports four cases operated upon with three recoveries and one death. In two of the four cases related,

the operation was undertaken under the impression that the growths were ovarian tumors.

Knowsley Thornton, (*British Medical Journal*, volume II, 1886 p. 902,) reports two cases cured by operation, and Marsh, in the same journal also relates one successfully treated.

R. F. Weir, (*N. Y. Medical Journal* volume, XLI, 1885, p. 311,) reports a case of hydatid cyst treated by small incision and evacuation of the contents of cyst; edges stitched to peritoneum and skin; patient died. Autopsy revealed defective drainage as the probable source of the sepsis.

J. T. Whittaker, (*Philadelphia Medical News*, volume XLIX, 1886, p. 75,) case of hydatid cyst of liver; after trying aspiration several times unsuccessfully, suppuration was induced; an operation was then performed by Dr. Connor. Small incision, edges stitched to peritoneum and skin. Death followed.

Including the present case, I have been able to gather the records of 25 cases occurring in the practice of English and American surgeons with but four deaths; 22 of these cases with two deaths are reported from English sources. Of the three American cases the one here presented seems to have been the only successful one. The following conclusions seem warranted by a study of the cases.

1st. Early operation, if possible before suppuration occurs; if not, the sooner thereafter the better.

2nd. The division of the operation into two stages, as recommended by Volkmann, for such cases as fail to show peritoneal adhesions.

3rd. Free incision; thorough evacuation and cleansing of the sack, with special attention to the drainage.

807 Cathedral Street.

Dr. J. Frank Crouch, who took the gold medal at the University of Maryland last month, has opened an office on Greenmount Avenue, near Eager street, in the office formerly occupied by Dr. Wilmer Brinton.

THE LUNG DISORDERS OF THE PREVAILING INFLUENZA.*

BY A. K. BOND, M. D.,
OF BALTIMORE.

About the end of 1889, the epidemic which had for some time prevailed in Europe, made its appearance in Baltimore. Manifesting its presence at first by various severe but transitory disturbances of the nervous and digestive systems, which yielded quickly to divers simple remedies, it produced in the minds of physicians the belief that its invasion of the city was a matter of little moment, and that its course could, in each individual case, be readily checked by proper remedies.

Gradually, however, the nervous and digestive symptoms have retreated into the background, and catarrhal disturbances of the respiratory tract, which observant physicians have all the while suspected to be the starting-point of the whole trouble, have come to the front.

That these disorders of the respiratory tract constitute the essential peculiarity of the epidemic, which may, therefore, be properly called an "influenza," is very probable for several reasons.

First, because they have been present in all cases. While the nervous symptoms varied greatly in different cases, and digestive disturbances could not always be detected, a disordered condition of the mucous membrane of the nose, the pharynx or the lower respiratory tract has, in the experience of the writer, been always perceptible, either as a simple congestion or as a catarrhal inflammation of the membrane. In its milder form, this symptom has generally been overlooked or considered of no importance.

Second, because fatal cases have generally, if not always, exhibited signs of disease of the lungs or bronchial tubes.

Third, because the respiratory troubles, alone of all the symptoms, persisted in spite of treatment. In the very beginning of the epidemic I learned this fact

*Read before the Medical and Chirurgical Faculty of Maryland, at its 92nd Annual Session, April 25th, 1890.

and formed the habit of telling my patients that these respiratory disorders, although moderated and prevented from serious hurtfulness by therapeutic measures, would continue for a considerable period, disappearing gradually, according to their own laws. This, of course, on the supposition that the patient would continue to reside in the infected district.

Inasmuch, therefore, as these disorders formed such an important part of the disease, and inasmuch as they appeared under so many guises, and differed in some respects from the diseases of these parts with which we are familiar, I have thought it worth while to discuss them briefly in this paper, confining my attention to a limited portion of the respiratory tract—the lungs and bronchial tubes. In preparing for my task I have endeavored rather to gain a clear comprehension of the whole subject and to mark the varying importance of each symptom in different countries, than to digest all the multitudinous reports which have appeared concerning the influenza.

As might be expected, the disease-processes excited in the lower respiratory tract by the influenza were complicated in many cases by other diseases which happened to prevail at the same time, as, for instance, diphtheritic, asthmatic and ordinary bronchitic affections. The disordered condition of the mucous membranes caused by the influenza-process doubtless presented an unusually favorable opportunity for the inoculation of various infectious matters.

The most serious complication of all was croupous pneumonia. I have not myself met with a case of this sort, and I do not believe that it was very often observed in Baltimore. The high death-rate in certain European cities was, however, due to this complication. Professor Nothnagel (as reported in the *Lancet*, Jan. 18th, 1890, p. 173), expressed the conviction that "the deaths from pneumonia which occurred in Vienna during the past few weeks, could not be regarded as due to influ-

enza directly, because an epidemic of pneumonia had been observed by him before the outbreak of influenza at the end of November 1889, which, becoming more severe, attacked many patients convalescent from influenza." Again, (as quoted in the *British Medical Journal*, January 11th, 1890, p. 97), he stated that "it was not this form (capillary bronchitis or bronchopneumonia) of pneumonia which created alarm, but the croupous variety, which really occurred at that time more frequently than before. It might be said with certainty that there was no close or essential connection between these diseases, but a certain external influence could not be denied. This was to be understood in the following way: Influenza and croupous pneumonia were two morbid processes, entirely different in character. The latter could never develop directly out of the former. If a patient with influenza became also affected with croupous pneumonia, this was only a coincidence, the one process having prepared the soil for the development of the other." The frequency of this complication varied greatly in different localities and at different stages of the epidemic. Thus, Finkler, of Bonn (*British Medical Journal*, February 15th, 1890, p. 384,) records among 45 cases of inflammation of the lung in influenza only two cases in which the symptoms of simple typical lobar fibrinous pneumonia were present; while Dr. Guitéras of the New York Health Department, states (*Medical Record*, January 25th, 1890, p. 95,) that during the heat of the epidemic lobar pneumonia was the more frequent and deadly, attacking patients, generally men past forty, during the stage of prostration, affecting frequently both lungs, and causing very high fever; while at a later period in the epidemic lobular pneumonia and bronchitis of the smaller tubes and capillaries was more frequent and very fatal, although less fatal than the other form. It seems certain, then, that croupous pneumonia was associated with the influenza only as a

complication—that it does not form an essential part of the true influenza process.

The disorder of the lungs and bronchial tubes, which is a part of the influenza process, may be limited to a mere congestion of some definite portion of the walls of the air-passages, or it may pass into a catarrhal inflammation of the lining-membranes with exudation of mucus or pus into the lumen of the air-passages, or in the most severe cases it may strike more deeply and cause some slight consolidation of the lung.

As to location, the process may be confined to a small region of the larger or smaller tubes, or it may gradually extend from the large bronchi downward to the pulmonary vesicles, or it may extend from one level of the lung to another, subsiding in one part as it develops in another. Often both sides of the chest present symptoms of infection at the same time, and it is probable that any part may be reinfected again and again at short intervals. These phenomena seem to indicate that there is a definite foreign causative agent which, settling upon some portion of the respiratory tract, passes through peculiar phases of development and decline, sometimes confining its action to its original location sometimes infecting neighboring regions.

The physical signs yielded upon examination vary according to the location and the existing phase of the disease. In some patients the process seems to be attended by very little exudation, the sounds upon auscultation indicating rather a congestion of the larger bronchial tubes with the collection in them of a small quantity of adhesive mucus; in others, fine crepitant rales, heard only at the end of deep inspiration, mark the site of the affection. These sounds usually give place after a few hours or days to moist bronchial or subcrepitant rales, which mark the transition from the stage of congestion to that of exudative inflammation. There is little or no interference with the normal percussion resonance. A peculiar feature of the disorder

is the limitation of the rales to one lung or to a small portion of one lung. I may cite several illustrative cases which I have recently treated.

One patient went about his work for weeks with sonorous rales in the right mammary region, distinct enough to be heard by the patient himself, or by a person who placed his ear within half a foot of the chest walls. He had never been affected in this way before. Upon auscultation these rales seemed to be dry, and to be located in the larger bronchi and confined to a region but one or two inches in diameter. Gradually the part healed without any evidence of more extensive infection of the lung.

A second patient, a healthy man, exhibited only fine dry rales upon deep inspiration over a district one or two inches in diameter in the infra-axillary region. The rales were evidently situated near the surface of the lung, in the finest bronchioles, or in the air-vesicles. They persisted for one or two days, and were then replaced by small scattered moist rales which gradually disappeared during convalescence. There was no sign of extension from the point first infected.

The third patient, a healthy working-man, became extremely ill with what seemed to be capillary bronchitis of the lower part of one lung. As time went by, first the middle and then the top of the same lung became involved in the exudative process, which affected also the larger tubes. When the inflammation was still intense in the upper part of the lung it was subsiding in the lower part, and gradually, after a month or more, the whole lung was restored to health. There was no consolidation of the affected lung, and no rusty sputum nor other sign of croupous pneumonia. The other lung remained healthy throughout the whole illness.

The general symptoms connected with the lung trouble of influenza vary greatly in intensity in different cases. The increase in temperature may be slight, or may be very noticeable, but it is largely

dependent upon disorders of other parts of the body. There is often, in the affected regions, intense and constant pain, which seems to be largely due to some accidental neuralgic complication similar to that which is so frequently met with in other parts of the body in this disease. In some cases where it is very severe, there are no signs of pleurisy; in other cases complicated with pleurisy, it is, as a writer has remarked, more intense than the pain of pleurisy. The sputum may be scanty or abundant. It is white, as in bronchitis, and may be streaked with blood, or perhaps be purulent, but in uncomplicated cases it is probably never rust-colored. Cough is generally present. It is sometimes very persistent and exhausting, preventing sleep. "Sometimes," says Dr. Eade (*Lancet*, Feb. 1st, 1890, p. 230), "the dyspnoea has been a striking feature, disproportionate to the extent of lung tissue affected, and occasionally becoming a most formidable symptom. It is doubtless due to a condition of partial 'pulmonary paralysis.'"

I have myself had no opportunity for post-mortem examination of the diseased lungs. Prof. Nothnagel (quoted in the *Lancet*, Jan. 18th, 1890, p. 173), states that "at the Vienna General Hospital, some cases of influenza were observed in which the post-mortem examination proved the presence of suppurative processes in the lungs and pleurae which have not been observed till now in the course of any other disease; so that they are believed to be peculiar to the influenza."

As my audience is largely composed of practising physicians, and not of pathologists, I shall not attempt to discuss the results of microscopic investigation of the secretions and tissues of the affected lungs, nor to describe the many unsuccessful efforts to isolate the influenza-germ.

The mucous membrane of the respiratory tract is doubtless the tissue through which the poison of influenza generally gains access to the system, and if so,

disorders of these parts must precede the other symptoms of the disease. But the upper air-passages may be the first involved, and implication of the bronchial tubes and lungs may occur at some later period, either by extension downwards of the disease-process, or by a new infection from without. In some cases the lung trouble is the first, and, it may be, the only prominent indication of the presence of the disease.

The *diagnosis* of the influenza-process in the lungs and bronchi is often difficult to establish with absolute certainty. During the epidemic, congestive or inflammatory disturbances in these organs may properly be ascribed to it if they are associated with the peculiar pains throughout the body, which are caused by its poison; or, if they are very persistent and are accompanied by great depression of spirits and loss of flesh and strength—especially if they are confined to a limited portion of one lung, or spread over it in the manner already described. From phthisis pulmonalis they are distinguished by their peculiar course and by the absence of serious or permanent injury to the tissues involved.

In the *treatment*, the ordinary remedies for bronchitis may be employed with benefit. It should be remembered that we have to deal with a process which tends to self-limitation, and which is attended with enfeeblement of the patient. I have treated many persons in whom the affection caused but little inconvenience, running its course in one or several weeks, and resembling in many respects a mild double bronchitis. Tonics were given, containing cinchona and iron, and cough mixtures were taken by the patient if he was sick enough to need them. In the beginning of the epidemic, I was disposed to confine patients to the house or bed as long as symptoms of extensive bronchitis—especially if it involved the small tubes—were present. Learning from experience that the symptoms might persist for weeks, and that open-air exercise in good weather was rather beneficial, I recommended, during

the rest of the epidemic, that patients should attend to their ordinary duties, short of fatigue, provided that they did not "feel sick" and had no considerable fever. Pain and cough were, in most cases, quickly controlled by fractional doses of sulphate of codeia, with moderate doses of carbonate of ammonia as a stimulant expectorant. In one case a child, two years old, with catarrh of the larger tubes, was kept awake for several nights by a cough which resisted moderate doses of codeia and bromides. Upon removal to the country, he recovered at once, gaining rapidly in general health. I lost two aged female patients with influenza-bronchitis. In one, the bronchitis was very slight, but was accompanied by depression of the vital powers and loss of appetite. The other, who had been much prostrated by family worries, took to bed complaining chiefly of pains in one side of the chest. Finding a general bronchitis of the medium-sized tubes on the affected side, I had poultices applied to the part, and ordered $\frac{1}{2}$ grain of sulphate of codeia, with 2 grains of carbonate of ammonia, in syrup of tolu, every four hours. Next day the pain had disappeared and the bronchitis was no worse. Great depression had set in, however, with nervous tossing and feverishness, intelligence being retained. Medication was now limited to large and frequent doses of brandy. The patient died next morning. In these two cases there was not sufficient disease of the lungs to seriously injure the patient, and the fever was not high, but death seemed due to the action of the influenza-poison on the nervous system.

In conclusion, I think it is well proven,

1st, That there is a peculiar disorder of the lungs and bronchial tubes due to influenza.

2nd, That it is marked by congestive or exudative inflammation of the affected surfaces, which is either limited to particular regions, or spreads slowly to adjacent parts of the air passages.

3rd, That it is due to inoculation by some foreign agent.

4th, That it is obstinate to treatment, but self-limited.

5th, That it predisposes to the inoculation of various other diseases.

6th, That, as a rule, it does not permanently damage the respiratory organs.

7th, That, in uncomplicated cases, death does not often, if at all, result from local interference with the functions of the lungs.

8th, That some poisonous agent is absorbed from the affected tissues into the general system, and causes a depression of the vital powers, which frequently produces death in the aged and feeble.

9th, That the best remedies are stimulant expectorants, mild opiates, tonics and removal to the country or sea-side.

FIBROID TUMORS COMPLICATING PREGNANCY.*

BY REVERDY M. HALL, M. D.
OF BALTIMORE.

Under the term "fibroid tumors of the uterus," we may have fibromata, fibromyomata, myomata, etc., indicating the relative predominance of fibrous or muscular tissue. These may be interstitial, sub-peritoneal, or sub-mucous. The intra-uterine growths being frequently polypoid. This most common site is said to be the posterior wall of the body, fibromata of the cervix being rare. Out of 74 cases of fibroids in the non-pregnant woman, it was found there were only four in the cervix. Sims found only 2 in 114 cases. They usually occupy the posterior lip of the cervix and rarely involve both lips. Apart from the changes which pregnancy and parturition cause in myomata, they may become hypertrophied, atrophied, fatty degenerated, vascular etc. In consequence of being vascular, oedema, congestion, infiltration, extravasation or gangrene may follow this vascu-

*Read before the Medical and Chirurgical State Faculty of Maryland, at its 92nd Annual Session, April 24th, 1890.

lar dilatation. Each of these conditions may affect the general health and cause peritonitis usually circumscribed. Myomata do not offer an insurmountable obstacle to pregnancy. Fecundation is not impossible, but there is a connection between sterility and the presence of these fibromata; while sterility may be a direct cause of the development of fibroids nearly all specialists think fibroids cause sterility. The changes in the shape, situation and cavity of the uterus, and the altered relations between the ovary and tube are mechanical obstacles to fecundation. Fibroids are more common in married, than in single women, since out of 1634 women, 1192 were married, and 442 single; or, nearly 3 to 1. Fibroid tumors are very common among colored females, for out of a large number of colored women whom I have examined all who had tumors, excepting those who had cancer, had fibroids. They are also very frequent among sterile women, for Sims found 119 cases of fibroid in 605 sterile women. The chances of fecundation are very much lessened by the presence of fibroids; for, of 1,554 women observed by various writers, 476 or 1 in 305 were sterile. Myomata being composed of tissues identical with that of the uterus, it is not strange that they are modified by pregnancy, but fibromata, fibro-myomata and myomata undergo different changes; these changes depend upon their seat. The more intimate their relations to the uterus, the more they will share in the physiological phenomena which take place in that organ and the more closely they partake of the nature of the uterus, the more pronounced will be the changes. Fibromata, the tissue of which is denser and more compact are less affected than myomata. Fibroid tumors increase in volume during pregnancy, and after delivery undergo an involution analagous to that of the uterus. The entire disappearance of a myoma is said to be rare. In many cases these tumors become flattened, so that they can not be felt during pregnancy; this being observed in interstitial myomata. The

placenta may be inserted on the fibrous growth itself or on the lower segment of the uterus. Pregnancy may pursue its regular course even in cases of multiple fibroids. Abortion and premature labor result about 1 in 4 cases. If the tumor be outside of the true pelvis, it rises with the enlarging uterus and only affects the pregnancy by its pressure. The myoma may undergo morbid changes which affect the general health. If the tumor is intra-uterine it grows simultaneously with the foetus; if located between the pelvic wall and the lower two-thirds of the uterus, these tumors whether sessile or pediculated are the most dangerous of all as regards pregnancy, especially if in the posterior wall. Haemorrhage is not common since it accompanies the sub-mucous variety. The tumor may, during pregnancy, compress the foetus and cause abortion. The location of the fibroids is of more importance than the number and size. If the tumor is situated at the cervix it may, by its size alone cause dystocia.

If the tumor is sub-mucous, it is pediculated, and if it is situated in the inferior segment of the uterus it will often be expelled before the foetus. If the tumor is situated higher up, delivery may be more difficult, and we may have to use forceps or perform craniotomy. If the tumors are interstitial, and occupy the lower segment of the uterus, they often cause serious difficulty. If they are higher up in the uterus, they rarely cause any difficulty. If they can be pushed up in the pelvis in front of the child, they often ascend above the presenting part, and thus allow its passage, or they are so softened and flattened out by the foetal part that they offer no obstacle to delivery. Here the size of the tumor, although it is an important element, is not the principal one, since it is rather the situation of the growth with reference to the pelvis. Large sessile, sub-peritoneal tumors with broad bases are especially apt to ascend during labor, caused by uterine contraction, the dilatation of cervix and the escape of the waters.

When the membranes rupture, the walls of the uterus retract, the longitudinal fibres contract, and the lower segment of the uterus is drawn up. Unfortunately, this ascension of the tumor does not always take place, whence arises insurmountable obstacles which may render Cæsarean section necessary. But aside from the difficulties attributable to fibroid tumors, mal-presentations of the fœtus are much more frequent in pregnancies implicated with fibroid tumors. In a number of cases reported by various authors the majority were not normal presentations. Breech presentations are regarded as the most favorable in cases of fibroid tumors and vertex the most serious. A case is reported by Dr. Charpentier in which the os was partially dilated, the fœtal head could be felt; the head was perforated, but the child could not be extracted, and the woman died undelivered.

I had a case some years ago, in which the woman, though pregnant, presented a large sub-peritoneal fibroid at the lower segment of the uterus; I had delivered her with forceps about two years previously; then no fibroid was perceptible. At the latter pregnancy no advancement of the head would take place on account of the fibroid; and in consultation with another physician we tried in vain to deliver with forceps. We waited for a few hours hoping that nature would possibly bring relief, but she died undelivered in the course of a few hours.

On the 25th of September 1889, I was sent for to see Mrs. J., age 38, primipara. She was suffering severe pains in her abdomen; she stated to me that she had missed her sickness about the middle of May, 1889. Upon examination her abdomen was very much enlarged, somewhat tender and tympanitic. A tumor sub-peritoneal was discovered above and to the right of the pubis. It was painful and very tender to the touch. Upon examination per vaginum another large tumor was found at the lower and posterior segment of the uterus. There was no bleeding from the tumor; she stated to me that she had been examined by a

physician some years previously, who told her she had womb trouble but did not indicate its character. During menstruation she had had no immoderate flow it lasting three or four days. On account of the pain I administered morphia, and as she had considerable nausea and sometimes vomiting, I gave her small doses of creasote and bismuth. The pains were not of that character which indicated the pains of labor, neither was the os dilated by them; they seemed to be of a colicky nature owing to a large amount of flatus within the bowels, and possibly some localized peritonitis around the tumor. She also suffered from dysuria. I continued in attendance upon her throughout the month of October and at times the pains and tenderness were so great as to compel me to use hypodermic injections of morphia to give relief. Believing that the case would be a very difficult one at the time of labor, I called in Dr. B. B. Browne at this time. He verified my diagnosis and remarked it would be well to watch the case as the time of labor approached. According to her testimony I need not expect labor until between the middle and last of February. On Tuesday December 10th, I was summoned to her hurriedly about 1.30 P. M., and found her in labor with the os well dilated, the cord prolapsed and the head above the brim. Pains were pretty severe. I immediately hastened for a consultation and as Dr. Browne was not in at that hour, I called in Dr. Chunn. I related to him the history of the case. The fibroid had flattened itself and had risen somewhat in the pelvis. A little later in the day I called in Dr. Browne; from his previous knowledge of the case he was enabled to take in the situation at a glance. We accordingly chloroformed her. The pulsation of the cord had ceased; this was at 4.30 P. M., no signs of life could be detected in the child. Dr. Chunn placed and kept her under the influence of the anæsthetic. Dr. Browne applied Tarnier's forceps to the head which was above and immediately over the pubis,

whilst I made pressure downwards and backwards upon the head. All efforts to dislodge the head from its position were futile. After having tried for a considerable while, the attempt to extract by forceps was abandoned and then he attempted to perform version, which after considerable labor and trouble he was enabled to do. The after-coming-head gave no trouble. There was born a well developed male child at full term about five hours after labor had fully set in.

The father of the child stated to me after the labor was completed, that its mother was mistaken in regard to her period of confinement, as her last menstruation had ceased in March instead of May. After labor, the womb contracted properly, and both tumors could be distinctly felt—the one above the pubis on the right side and sub-peritoneal, and the other in the lower and posterior segment of the uterus. The mother came out from under the influence of the anesthetic well and did nicely for the following three days, when peritonitis developed itself, and after an illness of five days, she died on the eighth day after confinement. As the time of labor approached, we had intended to hold another consultation in order to determine whether it was best or not to suggest to the family the necessity of a Caesarean operation, and if so, to watch the case more closely, and make preparation to perform the same, believing that the interests of both mother and child demanded it. I believed, from the history of the case, we had ample time to consider the case. I was not able to ascertain the time of quickening; the abdomen continued very much swollen, and I was led to believe that her normal confinement would take place in February, but as it was, her natural period ended in December, of which I was not aware until after delivery. I had ceased to visit her for several weeks previous to her confinement. The illness from which she suffered in September and October was no doubt due, in part, to a circumscribed peritonitis in the region of the sub-peritoneal fibroid, and

after delivery that circumscribed peritonitis developed into a general peritonitis, which caused her death eight days after confinement.

1019 Druid Hill Avenue.

Society Reports.

MEDICAL AND SURGICAL SOCIETY OF BALTIMORE.

STATED MEETING, HELD JAN. 9TH, 1890.

The 704th regular meeting of the Society was called to order, Dr. H. T. Rennolds in the chair.

Dr. Thomas A. Ashby made some remarks on

SURGICAL TREATMENT OF THE DISPLACED OVARY,

and exhibited several specimens.

He said displaced ovaries are more frequent than is generally supposed. The text-books dismiss the subject in a few words, and do not give the subject the attention it demands.

The ovaries are always displaced in uterine displacements. Sometimes they are displaced independent of the latter organ. In great relaxation of the broad ligaments, the ovary gets displaced in Douglas' cul-de-sac. Displacements are frequently associated with pyosalpinx and pelvic inflammations. In this case it may become fixed by inflammatory adhesions. The ovary is a very sensitive organ, and women have ovarian colic, caused by mechanical pressure, due to the abnormal position of the organ. The ovary is difficult to feel in examinations, profound anesthesia being necessary to do so. A chronic displacement, where the ovary is held down by inflammatory adhesions, is difficult to determine. About the only symptom is intense pain on pressure, which you have also in pyosalpinx, and a differential diagnosis is not easy. A woman who had chronic peritonitis came under his care. She had

intense pain for two years following delivery. On examination, the uterus was found to be immovable. A differential diagnosis between tubal inflammation, and displaced ovary was impossible, though the latter was thought to be most probable. She was placed on palliative treatment for three weeks, during which time frequent examinations were made. She did not improve. She suffered dyspareunia, which is almost diagnostic of displaced ovary. A laparotomy was proposed, to restore the ovary or to remove it if it were found to be pathological. The operation was accepted by the patient. The ovary was found to be diseased and encysted. All adhesions were broken up and it was removed. The tube is entirely occluded, which would suggest that the trouble began as an inflammation of the tube. The other ovary was not involved, and it was not disturbed. As soon as she came from under the influence of the anæsthetic, she said she was free from pain. She recovered in a week. She had no pain whatever after the operation, and her temperature did not go up. Within six days the walls of the abdomen could be pressed without exciting pain. The operation was done in an aseptic manner. The speaker thought the most important lesson to be learned in this case was the necessity for opening the abdomen for the purpose of making a diagnosis.

Dr. Geo. H. Rohé reported

A CASE OF SALPINGITIS, WITH ADHESIONS,

removed by laparotomy, with specimen. He said that Dr. Ashby had described the symptoms of his (Dr. Rohé's), case, as accurately as though he were reporting it instead of a case of his own. The patient was 32 years of age. She was a *religieuse*, and said that her trouble began after being exposed in the hot sun for five hours. Month after month she would have to take to her bed. She refused to be examined, and was put on palliative treatment. Her last attack was so long and tedious that an examination was

insisted upon, or the case would have to be abandoned. Examination being allowed, a diagnosis of pelvic peritonitis was made, which was concurred in by Dr. Opie, who saw the case. Dr. Jos. Price, of Philadelphia, did the operation in an aseptic manner. The incision after it had healed measured about one and three-quarter inches. The operation was done three weeks ago. She has had no pains since, and her temperature has never risen above 100° F. The pulse has ranged from 64 to 116. She was anæmic and pulled down from her sickness month after month, and her convalescence is slow. Had this patient had any use for her ovaries, electrolysis might have been tried.

Dr. Ashby said that Dr. Rohé's case is one where the radical operation for removal was advisable; the organs are not at all normal. He did not see what hope electrolysis would offer in a case of this kind. Had she been a married woman the removal of the ovaries would have been equally as strongly indicated. She would have been sterile, and her ovaries were of no use anyhow. The only thing they did was to keep up a painful and diseased condition.

Laparotomy is not so serious as is popularly supposed. When done early and under proper aseptic conditions, it is not necessarily fatal. The fatal cases are those that have been deferred too long.

Dr. Geo. H. Rohé reported

A CASE OF FIBROID TUMOR OF THE CERVIX,

removed by galvano-cautery, and exhibited the specimen.

Patient was 42 years old, and said she had been bleeding since last March. Careful inquiry developed the fact that she had had menorrhagia for several years. Her physician had not examined her. She fell into the hands of another physician, who made an examination and found a mass in the vagina.

Dr. Rohé saw the case in consultation

and operated on her on December 28, 1889, and removed the tumor with galvano-cautery. It was adherent to the posterior lips of the cervix, is pear-shaped and about $1\frac{3}{4}$ to 2 inches in its longitudinal diameter, and about $1\frac{1}{4}$ to $1\frac{1}{2}$ inches in the opposite diameter. A pledget of cotton, dusted with iodoform, was placed over the wound, and the vagina was packed with creoline gauze. The dressings were removed in four or five days, and the wound was found in good, clean, healthy condition, with no foul odor whatever.

Dr. Rohé also reported

A CASE OF EPITHELIOMA OF THE VIRGIN CERVIX,

removed by galvano-cautery, with specimen.

Was called to see a lady five days ago. She had been bleeding since November last. She was examined, and an eroded surface, just within the os, was found. Epithelioma of the cervix was diagnosed, and the cervix was removed with the galvano-cautery. There are two points of interest about this case: 1st, This is a superficial epithelioma, and the prognosis in this kind is much more favorable than in the deep or infiltrating epithelioma. This point, as to prognosis, was first made by Dr. N. G. Keirle, of this city. 2nd, The patient was single. This specimen is a typical virgin cervix, and does away with the theory that cancer of the uterus does not occur in the virgin. The dressings in this case was the same as in the other case reported above. Neither of these cases had been examined by the attending physician, both of whom were competent practitioners.

Dr. T. A. Ashby said he had seen only one cancer in the virgin; this was the second that had come to his knowledge. He sees many in married women. Dr. Emmett says, neglected erosions are apt to develope into cancer. He once operated on a lady who had been treated for four years for menorrhagia, and in all that time she had not been examined.

She became tired and consulted a young physician who was accorded an examination without any hesitation. He found a papilloma of the cervix and immediately said he wanted a consultant. Dr. Ashby was sent for and operated on the case. All the circumstances of this case emphasize the importance of examining cases early.

Dr. Wm. H. Norris said he knew of two cases where ladies had been treated for menorrhagia for several months, without an examination having been made. Both cases fell in the hands of other physicians, who, on examining, found the cause to be retained decidua. Of course, in neither of these cases should the woman have bled so long.

Dr. Wm. H. Norris related his personal experience and treatment of the gripe. He said when a boy of 14, he had Tyler's gripe, which was epidemic during the presidency of Mr. Tyler hence the name. On December 30 1889 was called to see several patients in one family; he found six, all sneezing. The room was very warm. He prescribed for them and left. The next day he felt badly, had pains in the limbs and an intense frontal head-ache. The following day his hearing became affected. On January 2nd, on coming home, he became dazed, and on entering his office and finding a number of patients there, he could not attend to them. The frontal head-ache continued and there was a copious watery discharge from the nose. He took $\frac{3}{2}$ ii of rochelle salt, following it in a few hours with another $\frac{3}{2}$ iss. At night he took grs. x of quinine with gr. v of Dover's powder and $\frac{3}{2}$ ii of potassium bromide. For three days he took grs. x of quinine and inhaled vapor of hæmamellis three times a day. After this he kept Tyrell's antiseptic powder by his bed, and sprayed the nostrils with a solution of it, of the strength of $\frac{3}{2}$ i to $\frac{3}{2}$ vi and found much relief from it. The treatment used at the dispensary does not answer in all cases. They have used antipyrine, but do not get good results from it. Quinine, he thought, was the

best remedy. We know little of the etiology of this disease. Dr. Salisbury of N. Y., thinks it the effect of an infusoria that is inhaled from the atmosphere.

Dr. F. C. Bressler said for the full stuffy feeling of the head, he wraps a piece of camphor in absorbent cotton and plugs one nostril for three hours, then the other, and found it gave relief. He finds a combination of quinine grs. iii phenacetine grs. v and ammon. mur. grs. v in aromatic syr. of yerba santa to be taken every three hours, to give good results in some cases.

Dr. J. F. Martenet said the combination of phenacetine with quinine reduces or obviates the tinnitus. His usual treatment is an active cholagogue, followed by quinine, then a carbonate of ammonia mixture. He has found phospho-caffeine to relieve the headache promptly.

Dr. H. T. Rennolds said cases vary a great deal in their symptoms. The catarrh is absent in some, while in others pain is the most pronounced symptom. In treatment he uses antipyretics, then expectorants, then tonics and gets good results.

J. WM. FUNCK M. D., *Sec'y.*

1710 West Fayette Street.

GENERAL TREATMENT OF BRIGHT'S DISEASE.

In the treatment of Bright's disease Senator advises the patient to seek a dry and equable climate, and to live almost exclusively upon a milk diet. Small amounts of white meats may be taken, but no red meats. Such vegetable food as herbs, cereals and fruits are permissible, but it is important to avoid spices. Wines diluted one-half with water may occasionally be taken.

Bamberger insists on an exclusive milk diet, and uses the following ferruginous pills :

R.—Chloride of iron . . . 3 grains.
Extract of taraxacum, q. s.—M.

One such pill to be taken three times daily.

Or,

R.—Sulphate of iron
Bicarb. of sodium } of each 75 grs.
Ext. of taraxacum } —M.

Make into sixty pills, of which three should be taken in the morning and three at night.

Semmola also insists on a diet of milk, and gives the following mixture :

R.—Iodide of potassium . 15 grains.
Phosphate of sodium . 30 "
Chloride of sodium . 1 drachm.
Water 3 ounces.
—M.

To be taken in twenty-four hours.

—*L'Abeille Médicale*, March 31, 1890.
—*Med. News.*

WIIY IS IT?

It is hard to understand why people of ordinary, or even of extraordinary intelligence in the main, often show such strange want of discernment when in need of medical aid. The man who will choose the most successful lawyer to conduct his case, who can tell you just where the best bargains are to be had, who buys and who sells at the right time, who judges rightly the merits of a sermon or the literary value of a book, will often pass by the best equipped physician, and with a surprising credulity will try the merits of some much-vaunted nostrum, or seek the advice of some charlatan celebrated for not what he has accomplished, but what he has the assurance to promise and the presumption to attempt. —J. H. Brierly, Glasco, Kansas, in "Does the Practice of Medicine Pay?" from *Kansas Medical Journal* of May, 1890.

Grateful passengers on the injured steamer *City of Paris* subscribed as a thank offering \$3,000 to endow beds at the Seamen's Hospital, Liverpool, for sick American and English sailors.

MARYLAND MEDICAL JOURNAL

Weekly Journal of Medicine and Surgery,

WILLIAM B. CANFIELD, A.M., M.D., Editor

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BALTIMORE, MAY 17, 1890.

Editorial.**LEAD POISONING IN CHILDREN.**

Do children suffer from lead poisoning? If so, how do the symptoms differ from those observed in adults? To the solution of these problems, which are not treated at all in text-books devoted to diseases of children, Dr. Brown (*British Medical Journal*, January 25th, 1890, p. 177) contributes an article which is, on account of his large experience, very valuable. He has found after careful research, only about a dozen cases reported which present nothing very striking. Having for three years devoted special attention to plumbism from contamination of water by lead service pipes, he

has collected notes of more than 42 cases of plumbism in children under fifteen years of age. He finds that such persons are far less susceptible to the poison than adults, tolerating lead very much as they tolerate mercury, antimony, and arsenic. In families where the adult members suffer from very severe symptoms of lead poisoning, the children using the same contaminated food or water, exhibit very mild evidences of the disease. Thus, in one house, the father and mother were both affected with lead palsy, colic, and constipation, both lacking the knee-jerk, and the mother having saturnine epilepsy while the two children, seven and nine years of age who drank the same lead-poisoned water, were not sick enough to require treatment, although both had the dark blue line on the gums.

The most common symptom in children is anaemia. Constipation, colic, frontal headache and absence of knee-jerk may be observed. Among 42 cases recorded by Dr. Brown in children, only one was severe. In this case, a child of four years had the blue line, colic, constipation, dysuria, and leg-tremor, being very anaemic and becoming gradually paralysed in the lower limbs. The father suffered in the same way, and the mother was very ill but not palsied. Under treatment the child slowly recovered. The drinking water contained 1½ grains of lead to the gallon.

Is the blue line often seen in children? Dr. Brown does not know that it has ever been observed during the first dentition. In four children under five years it was seen; in 18 others under ten years; and in 20 others under fifteen years. It is due to decomposition of the food with evolution of sulphuretted

hydrogen which combines with the albuminate of lead causing deposit of sulphide of lead in the papillæ of the gums. It is not found in children as often as in adults. It may be found on the gums of the molars, when the gums of the front teeth are free from it. Sometimes the mucous membrane of the opposing cheek is stained blue.

THE MEDICAL COLLEGE CONVENTION.

The movement to create a genuine improvement in the methods and thoroughness of teaching medicine in this country has met with a hearty and unexpected response. According to the last report of the Illinois State Board of Health, there are 132 medical schools in the United States, and of these, 24 expect to send delegates to the convention of medical colleges, at Nashville, next week, and 8 have expressed themselves as favorably inclined to the plan, but have not, up to present writing, named their delegates.

The principal topics of discussion will be a three-year term and a four-year time of study, written, as well as oral examinations, preliminary examinations, a graded curriculum and laboratory instruction. In fact, whatever else tends to elevate the standard of the schools will also be brought forward. Some schools have sent no delegates, because they have complied with all these requirements. These are the very ones whose delegates would have most weight, for their presence and co-operation would stimulate the others. This movement deserves the support of all respectable schools.

Correspondence.

THE CONFERENCE OF MEDICAL SCHOOLS.

Baltimore, May 13th, 1890.

Editor Maryland Medical Journal:

DEAR SIR:—The following schools have announced delegates to the Nashville Conference of Medical Schools:

Universities of Pennsylvania, Maryland, Michigan, California, Virginia, Tennessee, Georgetown University, Arkansas Industrial University, University Medical College, Kansas, Northwestern University (Chicago Medical College), Syracuse University. Medical colleges: Meharry, Nashville; Miami, Cincinnati; Kansas City; Columbus; Gross; Memphis; Louisville Hospital College of Medicine, Starling Medical College, Kentucky School of Medicine, Louisville; Michigan College of Medicine and Surgery, Detroit; College Physicians and Surgeons, Woman's Medical College, Baltimore Medical College, Baltimore.

The following have replied favorably but not yet announced their delegates:

Universities of Southern California, and Colorado; Staff of Johns Hopkins University. Rush Medical College, College of Physicians and Surgeons, New York; Jefferson, National (Columbian University), and Missouri Medical Colleges.

The prospects are, therefore, that there will be a very general meeting of schools at Nashville. Replies continue to come in daily.

Yours respectfully,

EUGENE F. CORDELL, M. D.,

*Secretary of Conference of
Baltimore Schools.*

2111 Maryland Ave.

P. S.—The meeting will be held at Nashville, May 21st, at 3 P. M.

Reviews, Books and Pamphlets.

The International Medical Annual and Practitioner's Index for 1890. Edited by P. W. WILLIAMS, M. D., Secretary of Staff, assisted by a corps of thirty-six collaborators—European and American—specialists in their several departments. 600 octavo pages. Illustrated. \$2.75. E. B. Treat, Publisher, 5 Cooper Union, New York.

The eighth edition of this "Medical Annual" varies little from its predecessor. The subject of baths has been treated more at length, and it is probably the first book to contain an account of the recent epidemic of influenza. It is larger than last year, and contains more illustrations. It seems to be the publisher's endeavor to make it an important book in the physicians' library, and the larger edition and increased sales seem to show its popularity.

Some Fallacies Concerning Syphilis. By E. L. KEYES, M. D., New York City. Detroit : George S. Davis, 1890. Pp. 71. Price, cloth, 50 cents, paper, 25 cents.

This is in the form of thirteen fallacies most commonly entertained by the profession and public, and remarks on each one. The same conclusions, in some cases, have probably been reached by others, but on the whole, it is a very satisfactory book to read in treating the disease. In fact, it is a good book to quote in part to certain anxious syphilitic patients, and in parts it makes one think that syphilis is not such a bad thing to have, after all. There is much good in the monograph.

Sketch of the Late Dr. J. Edward Turner, the Founder of Inebriate Asylums. By T. D. CROTHERS, M. D., Hartford, Conn. Reprint from the *Quarterly Journal*,

The Treatment of Torticollis (Wry-Neck). By CHARLES F. STILLMAN, M. Sc., M. D. Chicago. Reprint. 1890.

A Practical Splint for Inflammatory Conditions of Joints. By CHARLES F. STILLMAN, M. Sc., M. D. Chicago. Reprint. 1890.

A Rational Brace for the Treatment of Caries of the Vertebræ (Pott's Disease). By CHARLES F. STILLMAN, M. Sc., M. D., of Chicago. Reprint. 1890.

Miscellany.**A RATIONAL TREATMENT FOR DIPHTHERIA.**

A. E. Hoadley (*Times and Register*, December 21, 1889, p. 800), advocates the use of the following formula :

B.—Potassi chlorat., 3*i* ;
Tr. myrrhæ, 3*iii* ;
Ac. carbolici, gtt. iv ;
Mel. despumat., 3*iv* ;
Aquaæ ad q. s., 3*iv*.
Ft. mistura.

Sig.—Fifteen drops every half-hour, day and night.

If the disease extends to the larynx or the nasal passages, this mixture should be used as an atomizer. In certain cases, he adds to the myrrh mixture bichloride of mercury 1 to 3000, and in malignant cases he gives maximum doses of iron. He also uses this mixture as a prophylactic.—*Arch. of Pediatrics*.

PREScription FOR PRURITUS VULVÆ.

B.—Sodium hyposulphite . . . 3 $\frac{1}{2}$
Carbolic Acid gr. 30
Glycerin 3 $\frac{2}{3}$
Water 3 $\frac{1}{2}$

Sig.—To be applied locally.

—*Buffalo Med. and Surg. Jour.*

Mr. A. T. White, of Brooklyn, has erected a model tenement house in that city.

Medical Items.

Drs. William H. Norris and A. V. Gossweiler have been re-elected to the Eastern Dispensary.

Dr. Joseph H. Warren, of Boston, will read a paper by phonograph at the meeting of the American Medical Association at Nashville.

A policlinic, or medical institute, similar to the policlinic at Vienna and Berlin, will be opened at Paris at 28 rue Mazarin, in a few days.

The French journals say little about the International Medical Congress to be held at Berlin in August and few French names are on the programme.

Dr. George H. Rohé has removed to 18 West Franklin Street, between Charles and Cathedral. Office hours:—2 to 5 P. M.

It is said that there has been discovered in Colorado a spring whose virtues equal, if not excel, the waters of the celebrated Hunyadi-János spring.

The time for the reception of entries to the International Medical Exposition has been extended, so that those coming from the United States may be received after May 15th.

We regret to announce the death of Dr. Küchenmeister, the well-known helminthologist, which took place at Dresden on April 13th. He was in his 69th year.

Dr. E. W. Eilau has been elected Professor of Physiology, Pathology and Hygiene in the Baltimore University School of Medicine, and Dr. E. M. Reid has been transferred to the chair of Nervous Diseases and Diseases of the Chest.

The Homœopathic physicians of this

city are not at peace among themselves. A rupture will probably result in the formation of another homœopathic dispensary, which the most ardent advocate of that calling will hardly consider a necessity.

The first annual meeting of the St. Mungo's Medical College, Glasgow, was held recently, and the reports showed a very prosperous year with a bright outlook for the future, the scope of the college comparing favorably with that of any medical school in Great Britain.

It is announced that the membership of the New York Physicians' Mutual Aid Association has so increased that the trustees are now enabled to pay \$700 on the death of a member. At the present death-rate the annual cost of membership is estimated at about \$11. Such an association would pay in Baltimore.

The sensational reporter of a Paris daily, lately published full particulars of an operation performed to reduce obesity by removing the sub-cutaneous fat. The details of the operation and the names of the surgeons are given. The whole thing is a hoax, as no such operation was performed in Paris, and the names of the surgeons are not to be found in the directory. Some American journals have already announced the operation as a fact.

The Association of American Physicians which has just closed its fifth annual meeting in Washington D. C., elected the following officers for the ensuing year: President, Dr. C. H. Mastin of Mobile; first vice president, Dr. John Collins Warren, of Boston; second vice president, Dr. Stephen Smith, of New York; secretary, Dr. J. R. Weist, of Richmond, Ind.; treasurer, Dr. Phineas S. Connor, of Cincinnati; recorder, Dr. J. Ewing Mears, of Philadelphia; counsel, Dr. Stephen H. Weeks, of Portland, Me.; committee of arrangements, Dr. John S. Billings, United States Army.

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THERAPEUTIC PROGRESS DURING THE PAST YEAR.*

BY EUGENE F. CORDELL, M. D.,
OF BALTIMORE.

[Being Chairman's Report for the Section on Materia Medica and Chemistry.]

There have been no great additions to our therapeutical resources during the past year. Nevertheless, good work has been done in demonstrating the falsity of extravagant claims made in the case of several new remedial agents, and in establishing the exact value of those with which we were previously made acquainted. Interest still centres in the class of (a), antipyretic-analgesics and (b), hypnotics. Perhaps the most important contribution of the year is an agent belonging to the former class, viz.: exalgine or methyl-acetanilide.

Exalgine (*ex, algos*) derives its name from the most important of its characteristics—its power of relieving pain. It is one of the four isomeric methyl derivatives of acetanilide, and occurs in needles, or long, colorless, tablet-like crystals, sparingly soluble in cold water, quite soluble in hot water and in water to which a little alcohol is added; it is without taste or smell. Its chemical composition is $C_9H_{11}NO$. Physiologically, it is closely allied to acetanilide and antipyrin; its effects on the sensorium are, however, more marked, while its antipyretic powers are less, depressing the temperature $1-3^{\circ} C$. The dose is 4-6 grains two or three times a day. All forms of neuralgia are said to be benefited by it, including visceral neuralgia, and it sometimes relieves where antipyrin and antifebrin fail. It antagonizes convulsive symptoms and checks polyuria. It produces no gastro-intestinal irritation, no rash or cyanosis, but occasionally causes slight vertigo and tinnitus. The system

*Read before the Medical and Chirurgical Faculty of Maryland, at its 82nd Annual Session, April 25th, 1890.

becomes habituated to its use. In fatal doses, it appears to paralyze the respiratory centre. It is eliminated by the kidneys, diminishing markedly the urinary secretion.

Dujardin-Beaumetz, in discussing the agents of this class (the antipyretic-analgesics), classifies them according to their value and properties as follows :

1st, Antipyrin : soluble ; but little toxic ; causing scarlatiniform eruption, sweats and collapse, even in small doses; diminishing the activity of the brain and cord ; especially useful in migraine and the congestive neuralgias ; anti-choreic.

2nd, Exalgine : second only on account of its relative insolubility ; never producing an eruption ; to be given in moderate doses, as four grains twice or thrice a day, in capsules, or preferably in solution, as with tincture of orange-peel, syrup and water.

3rd, Phenacetine : third on account of its great insolubility ; this, however, an advantage; rendering it non-toxic ; to be given in capsules, seven and a half grains once or twice a day, in neuralgia.

4th, Acetanilide : placed last, not because less powerful, but because of cyanosis, which is calculated to frighten the patient and attendants, but is not harmful ; may be given for months or years without other effect than a passing bluish discoloration of the face and mucous membranes ; very active ; very cheap ; requiring a large quantity of alcohol to dissolve ; best given in capsules, five to ten grains, thrice daily.*

It is thus seen, from the estimate of this distinguished therapeutist, that these four important new remedies possess remarkably similar characteristics, which makes it hard to gauge their relative value.

Bardet, of Paris, cautions us to be sure, in using exalgine, to get the genuine article, which may be known by melting at 214° F., since isomeric bodies are being sold under the same name, which are therapeutically nearly inert.†

Another antipyretic brought recently into prominence is *pyrodine*, one of the numerous derivatives of coal-tar, a white, crystalline powder, sparingly soluble in cold water, without odor, and nearly tasteless. It is a powerful antipyretic and analgesic, and is given in the dose of twelve grains or less, once in 18-24 hours. Its use is accompanied by profuse sweating, and if continued a few days, a toxic effect on the blood, *haemoglobinuria*. It cannot, therefore, be regarded as a safe remedy for use, and we shall probably hear little more of it.‡ Its active principle, hydracetine, has also been employed with similar results.

Thallin once a prominent antipyretic, has also proven a pronounced toxic agent, and has been relegated to obscurity.

Among hypnotics, *sulphonal* has continued to exact a large share of attention and research. When it was first introduced to the notice of the profession, great hopes were entertained that at last an ideal hypnotic had been found. For a time the reports were almost without exception favorable, but as time wore on they became less and less so, and it can now be said that this agent has fallen much below the position which it occupied when we last met. In noting the accumulating unfavorable evidence, the editor of the *Therapeutic Gazette* (Dec. 15, 1889), says : "The testimony as to the inconveniences, and indeed almost the dangers attending the use of sulphonal, is so rapidly accumulating, that it is evident its field of usefulness is becoming greatly restricted."

Among the drawbacks to the use of the remedy are its expensiveness, its insolubility, the uncertainty of the dose and effect, the slowness of action, the persistency of the hypnotic effect, cumulative action and unpleasant and even dangerous sequelæ. Among the toxic effects reported are vomiting, faintness, tinnitus, vertigo, headache, muscular ataxia, tottering gait, excitement, delirium, delusions, cyanosis, pulmonary

**Therapeutic Gazette*, Dec. 15, 1889.

†*Therapeutic Gazette*, Sept. 15, 1889.

‡Dr. Lafleur, of the Johns Hopkins Hospital, has confirmed the unfavorable report of this agent.—Johns Hopkins Hospital Reports.

congestion, collapse. These ill effects were usually seen most after large or repeated, but also sometimes after small, doses, and death has followed a moderate dose. It is difficult to avoid the conclusion from the contradictory reports that there must be great variation in the composition of the drug, and that toxic principles must be present in some preparations and absent in others. To a considerable extent, doubtless, the ill effects may be obviated by restricting the dose. Ordinarily, this should not exceed ten or fifteen, or, at most, twenty grains, and remembering its cumulative effects and the slowness of its elimination owing to its insolubility, in case of repetition the dose should be diminished. In practice among the insane, however, all experience proves that less than 30 grains is useless.

Chloralamide is a combination of chloral and formamide, occurs in colorless, odorless crystals, which have a faintly bitter taste, are readily soluble in water, and still more so in alcohol. It is given in 15-45 grain doses, is pleasant to take, and cheap. Its effects are manifested more slowly than those of chloral, but it is claimed to be free from the depressing effect upon the heart and circulation exhibited by the latter. It is not free, however, from unpleasant after-effects, and frequently fails to produce hypnotism. The estimate of its utility varies. Lettow found it eminently satisfactory in 74 per cent. of his cases; with Fürbinger and Robinson it failed in 46 per cent., and at the Johns Hopkins Hospital, where it was used under Professor Osler's directions in 50 cases, the following results are reported (Toulmin):

Total number of doses administered	186
Undoubted hypnotic action in	86
Negative results in	85
Results uncertain in	15
Ill effects (headache, mental confusion, or derangement), in	16*

Somnal is the name given to a mixture of alcohol, chloral and urethan, by Rad-

lauer, a druggist of Berlin, who claims that in 30-drop doses it produces a quiet, deep and natural sleep, commencing half an hour after administration and lasting six to eight hours. But Liebreich[†] states that the inventor does not know the composition of the agent and that his claims are fallacious, and Robinson (assistant of Prof. Fürbinger), finds that it exerts a hypnotic effect only in about 30 per cent. of cases, besides having a very undesirable, and occasionally even dangerous, secondary action on the heart.

Amylene hydrate has established for itself a place scarcely inferior to sulphonial. It acts rapidly, producing asleep of some six to twelve hours duration. The respiration, circulation and digestion are not notably affected. On account of its irritating character, it should not be given by the mouth when there is gastric disorder or nausea. It may, however, be given by the rectum. Because of its disagreeable taste and odor, it is not suited for use by fastidious patients and children. Slight toxic effects are sometimes observed, as headache, nausea, oppression about the chest, etc. The dose is 30 to 45 grains, and it is best given in capsules, or in mixture flavored by licorice.

Urethan is a mild and uncertain hypnotic in the dose of 30-60 grains. It is very soluble in water and its taste is not offensive.

Professor Leech[‡] gives the following order as representing the hypnotic power of the several drugs mentioned and paraldehyde: 1, sulphonial; 2, amylen hydrate; 3, paraldehyde; 4, urethan. None of these, he states, equal chloral hydrate in certainty of action, although either of the first two may succeed where the latter has failed. None of these agents are adapted to the insomnia due to pain.

The search for an antiseptic which shall be efficient, and at the same time harmless, continues. *Creolin* is the latest agent claiming our attention from

[†]Therapeutische Monatshefte, Dec., 1889.

[‡]British Medical Journal, Nov., 1889.

this direction. It is derived from creosote, but its composition has not been determined; its antiseptic power is probably to be ascribed to phenol; it contains scarcely a trace of pure carbolic acid, it is non-volatile, readily forms an emulsion with water and is not poisonous. Dr. Spaeth and others took daily eight grammes for a length of time without local or general bad consequences. A patient of Dr. Kortüm drank by mistake sixty grammes in a five per cent. solution without experiencing any bad effects. It is lubricating, non-corrosive even when pure, does not injure clothing, and can be washed out of material without leaving a spot. Among other advantages claimed for it are, that it is a deodorizer and styptic, parasiticide, easily distinguished by color and smell, and cheap, the price being about one-fourth that of carbolic acid. A two or three per cent. emulsion is employed for external use. We are cautioned against imitations, and Pearson's preparation is said to be the best. Further observation is needed to establish the exact value of this preparation.*

"By very simple processes, most individuals, at least of some races, and many individuals of all races, can be thrown into a condition of perverted consciousness, in which they are automatism, controlled by the will of the operator, insensitive in such portions of the body as he declares are devoid of feeling, sensitive when he declares sensation exists, physically, morally, seemingly in all respects an *alter ego* to the man who commands them."† This state is known as *hypnotism*, from its resemblance to natural sleep. Now it has been found that this state may be utilized in the relief of various ailments not only functional, but also structural, among which are included menstrual troubles, rheumatism, gout, constipation, diarrhoea, general debility, paralyses, especially infantile, cramps from over-use, etc. It is principally in France that

hypnotism has been practised, and almost miraculous results have been claimed there from it. The method of treatment is simply by suggestions made to the patient during the hypnotic state, as for instance, that she would not have her customary pain during her approaching menstrual period. I will not lengthen this report by a recital of the wonderful results that have been secured by this method. There can be no doubt that they have been actually secured, but there is some doubt as to the connection of the suggestion and the result. It is in the neurotic class of patients that hypnotism alone is possible, and Charcot asserts that there is a very close relation between hypnotism and hysteria. Now we are well aware of the power of mental impression upon the subject of this protean malady. Hypnotism is therefore probably only faith-cure under another name. In this connection two cases exhibited at the clinic of Professor Wood of Philadelphia, have an important bearing. One was a case of almost complete paraplegia, the other had suffered from incessant tremor of the right hand, exactly simulating paralysis agitans; both were doubtless hysterical in character. Both were rapidly cured by hypnotism without any suggestions whatever being made during the hypnosis. Professor Wood commented upon the want of control experiments in the elucidation of this subject.‡ In this connection it is of interest that hypnotism has been abandoned at Professor Charcot's clinic and that Meynert, of Vienna refuses to employ it, because it weakens the will, which in neurotic subjects it is desirable to strengthen. Virchow and von Ziemsen also oppose it. From extensive personal experience, the latter finds its influence only transient even in slight functional disturbances, and that it is powerless to mitigate the severer neuroses, epilepsy, chorea and paralysis agitans, to say nothing of deep-seated organic disturbances. The power for harm too is

*See Deutsche Medicinische Zeitung, July 1889.

†Therapeutic Gazette Sept. 1889.

‡Therapeutic Gazette, January 1890.

great, since it may convert a slight hysteria into a "grande hystérie," as noted by Charcot; and finally it may possibly place in the hands of unscrupulous persons the power to commit crime without the possibility of their detection. So far we seem to have escaped a visitation of this therapeutic vagary, but it is almost too much to expect that a country and people whose imitative faculties are so good as ours will remain altogether inhospitable to this novelty.

During the year an important addition has been made to the therapeutics of spinal diseases, especially of locomotor ataxia, viz: *suspension*. By means of Sayre's apparatus, patients are suspended every other day, so that the toes just touch the floor. At first the treatment lasts only a half-minute, but after eight or ten séances it is prolonged to three minutes. The treatment is said to be harmless, but should never be entrusted to the patient or his attendants alone. Of eighteen cases of pronounced tabes with 400 séances extending over a period of four months (Charcot), fourteen were benefited, eight remarkably. The improvement was evidenced by immediate improvement in the gait, by disappearance of Romberg's symptom, by a lessening or cessation of vesical troubles and lightening pains, and by return of sexual power. The patellar reflex, however, did not return, and the pupil symptom persisted. These results have been confirmed by Dujardin-Beaumetz and Bernhardt. So far, no cures have been reported; still, in an affection with so hopeless a prognosis as locomotor ataxia and with the paucity of reasons at our command, we may well welcome this addition. A semi-suspension has also been practised with good results. This consists in making the patient take hold of the top of a door and lift his feet off the floor.

Of the utility of *electricity* as a therapeutic agent, there can be no doubt, but that fashion has much to do with its popularity there can be also little question. It is a good and harmless diversion

for patients and satisfies them that the physician is not neglecting them. With the rich, it is a fruitful source of income to the profession. Static electricity may be ignored, the galvanic and faradic currents answering all the purposes of the physician. The galvanic current may produce chemical changes, which, according to their degree, may be either stimulant or destructive; the interrupted, or faradic current, promotes functional activity. As a therapeutic agent, the use of electricity is limited, extending only to the treatment of the neuroses and the symptoms of organic disease. So good an observer as Dr. M. Allen Starr, of New York, declares that after its constant use for ten years he has been disappointed in the results. Dr. L. C. Gray in discussing which pole should be used in faradism, says, that notwithstanding the chemical, physiological and sensory differences between the negative and positive poles, he had never been able to satisfy himself as to their therapeutic difference, and he lays down the following rule: When one pole does not agree, try the other, and if that does not agree, stop using electricity. This simplifies matters very much.* In connection with this subject, I may call attention to the fact that Baltimore excels at this time in the manufacture of electric batteries. The advantages of the Barrett dry-cell batteries are doubtless known to you all, and it is only to be regretted that the manufacturers by their exorbitant prices have placed them beyond the reach of so many of the profession.

In 1888, Surgeon-Major E. Lawrie, the resident surgeon in Hyderabad, India, applied to the local Government of that province for the appointment of a commission to investigate the action of chloroform, on the ground that the views entertained in the profession of the action of this anaesthetic were erroneous. A commission was accordingly appointed, and as a result of their investigations they reported that "chloroform may be given by inhalation with perfect safety,

*New York Medical Record, April 6, 1889.

and without any fear of accidental death if only the respiration be carefully attended to throughout." This conclusion was naturally received with suspicion and doubt, and a second commission was appointed to repeat the experiment on an enlarged scale, and Dr. Lauder Brunton, the eminent teacher and pharmacologist was added to it. The conclusions of the second Hyderabad Chloroform Commission have just been published and deserve our careful study. Four hundred and thirty experiments were performed upon different animals—dogs, monkeys, goats, and horses, and we may epitomise their most important conclusions as follows:—The recumbent position is essential. Absolute freedom of respiration should be secured. An apparatus should not be used. The administrator should avoid giving the vapor in too concentrated a form at first. As soon as the eye-ball can be touched without exciting winking, the operation should be commenced. As a rule no operation should be commenced until full anaesthesia is secured. *The administration should be guided entirely by the respiration, any interference with which, however small, should cause an immediate cessation of the anaesthesia.* In embarrassed respiration, pull the lower jaw forward to raise the epiglottis, and practise artificial respiration. If respiration stop, lower the head, draw forward the tongue and practise artificial respiration. Atropia should not be used before the anaesthesia, but alcohol may be useful. "*The commission has no doubt whatever, that if the above rules be followed, chloroform may be given in any case requiring an operation, with perfect ease and absolute safety so as to do good without the risk of evil.*"[§]

These results are so completely subversive to our previous views regarding chloroform anaesthesia, that it is hardly to be expected that they will obtain immediate acceptance at the hands of the profession in this country and Europe, especially since they are based exclusively upon experiments upon animals—mainly

dogs. They are nevertheless, very striking and call for renewed physiological and clinical investigation of the subject. In this connection, the fact has been revealed that Syme laid stress upon attention to the respiration rather than the circulation in chloroform anaesthesia. It is also a significant fact that the conclusions reached by the Committee are contrary to those held by Dr. Brunton previous to the investigations in which he took part.

Among minor points to which the section would call attention are the following: the use of glycerine enemata for constipation, 3*i-ii* in an adult and 3*ss-i* in a child exciting reflex peristaltic action in a few minutes without pain or irritation. It is especially adapted to use in pregnancy and in children. Messrs. Sharp & Dohme, of this city, prepare a very beautiful suppository, which can be used in whole or part for different ages; it contains 95 per cent. of glycerine.

Prof. Field, of Dartmouth College, draws attention to the extreme insolubility of the alkaloid strychnine, of which such large use is made in the manufacture of pills and granules. The sulphate of strychnia should always be substituted. He recommends the following improved formula for a purgative granule, one granule being usually sufficient to produce purgation:

R.—Aloin., . . .	gr. $\frac{1}{2}$
Strychninæ sulph.,	gr. $\frac{1}{40}$
Extr. belladonnæ, .	gr. $\frac{1}{10}$
Pulv. ipecac., .	gr. $\frac{1}{2}$
Ft. pillula i.	

The same gentlemen refers to the overdosing with digitalis, and says that the dose should not be greater than five drops three or four times a day.*

Remarkable results are claimed by a Russian observer (Mandelstanu, of Kazan), from the use of phosphorus in rickets. He gave it in the dose of about $\frac{1}{33}$ gr. in cod-liver oil, once or twice a day. Of

214 patients, 120 were cured and 43 benefited. The benefit is seen after two months.†

The difficulty of finding a suitable excipient for permanganate of potash seems to be overcome by the recommendation of lanolin. In the proportion of one part of lanolin to ten of the permanganate, the pills are said to be easy to make, to be hard, and to retain their shape perfectly.‡

Sir Alfred Baring Garrod has called attention to the value of sulphur in small doses in habitual constipation, hepatic sluggishness, piles, rheumatoid arthritis, gout, chronic muscular rheumatism, skin diseases, and pulmonary affections. He administers it in a lozenge containing milk of sulphur, 5 grains, and cream of tartar, one grain.§

Dr. Sternberg has recommended a formula for the treatment of yellow fever, which commends itself on theoretical grounds, and has also given satisfaction in actual practice. It is based upon the highly acid condition of the stomach and urine, and the probability that an acid medium may favor the development of the germ in the intestinal canal. It is composed as follows :

R.—Sodii bicarb., . . .	3 iv
Hydrarg. chlorid. cor.,	gr. $\frac{1}{2}$
Aquaæ puræ, . . .	qt. j.
M. S. $\frac{3}{4}$ i $\ddfrac{1}{4}$ every hour, ice-cold.	

Prof. H. C. Wood states that the only remedy he has found of any service in hay-fever is cocaine, administered in suppositories made with cocoa butter, each containing gr. $\frac{1}{2}$ atropine and 1 gr. cocaine, to be introduced high up in the nostril while the patient is recumbent.

This report would not be complete without allusion to the National Formulary of Unofficial Preparations, issued by authority of the American Pharmacae-

tical Association, in 1888. It is an attempt to provide an authoritative standard for the large number of drugs and formulæ which are in use by the profession, but for which the United States Pharmacopœia makes, as yet, no mention. It is an excellent work and deserves to be generally adopted. I am glad to announce that it has been recommended by a committee of this Faculty and has been incorporated into the last edition of the United States Dispensatory.

2111 Maryland Avenue.

THE NATURE AND TREATMENT OF HYSTERICAL PARALYSIS.*

BY GEORGE J. PRESTON, M. D.,

Professor of Physiology and Diseases of the Nervous System, College of Physicians and Surgeons, Baltimore.

[Being Chairman's Report of the Section on Practice of Medicine.]

Hysterical paralysis is one of the most prominent and characteristic members of that group of symptoms to which has been applied the general term, hysteria. Among English-speaking people, as is well known, this disease does not exist with the frequency nor severity that is seen in other nations. But even if this fact be taken into full consideration, it is remarkable how unwilling English and Americans, lay and professional, have been to award it a place among bona fide diseases. The laity of these countries even now, and unfortunately a considerable proportion of the medical profession also, regard hysteria most unqualifiedly as a feigned disease and the hysterical subject as an out and out malingerer. The very term is one of reproach, so that in this country the physician is generally obliged to retire behind such euphemisms as "functional, nervousness" and the like, when speaking of the disease. I

*Medical Press and Circular, July 17, 1889.

†Phar. Journal and Trans., National Druggist, July 1, 1889.

§Lancet, April 6, 1889.

||Therapeutic Gazette, Dec. 1889.

*Read before the Medical and Chirurgical Faculty of Maryland at its 92nd Annual Session, April 23rd, 1890.

have seen a mother's face express almost as much indignation when I told her that her daughter was hysterical, as it would have done had I said "your daughter is a fool," or "she is a liar." The word, hysteria, cannot, of course, be defended upon philological grounds, since, like so many other ancient terms in medicine, its primal significance has utterly faded. The uterus was supposed to be the seat of this affection, and, more than this, was thought to wander over the body at will, a state of affairs that the gynaecologist and obstetrician of that day must have seriously objected to. To-day we understand the term, hysteria, to comprise a fairly definite group of symptoms, and it is rather to be regretted that such a stigma of disgrace is attached to it, that we are hardly able to use it without running a risk of being misunderstood.

Of all the diseases classified as functional, hysteria probably represents the purest type, and to this fact is due the very frequent misconception of its nature. On the one hand, the extent and severity of the symptoms would seem to point to organic disease; this mistake, of course, is most common with the laity. While on the other, the patient's inconsistency and the contradictory nature of the symptoms not unfrequently lead to the mistaken and unfortunate diagnosis of malingering, or a vicious disposition.

The great fundamental fact underlying this frequent misconception of the nature of hysteria is obvious; we do not understand the intimate relations and working of the brain.

We recognize with perfect ease a functional disease of the stomach, for example, for we know how stomach digestion is carried on, and what and where the fault is when it occurs. With the brain, however, it is very different; we simply see the results of the work, and are compelled to fall back, in great measure, upon theory to explain how such results have been attained. Experimental physiology, however, and pathological records in the light of this work, have given us so

many indisputable facts, and so many pregnant suggestions, that we may be said to have now what scientific men are fond of calling a good working theory. The limits of this paper do not admit of even allusion to the many ingenious, amusing, or absurd theories which have been propounded to explain the nature of hysteria. What may be said concerning the nature of hysterical paralysis will hold good, with certain modifications, in the case of most of the other prominent hysterical phenomena.

In the first place, hysterical paralysis is almost certainly of cortical origin. As we shall see when we consider its symptomatology, the preservation of the reflexes, of electric reactions and of nutrition, all point most strongly to the cerebral cortex as the origin. Yet, we must look beyond the motor regions of the cortex. A patient with most marked hysterical paralysis will, under certain conditions, use the paralysed members as freely and forcibly as if nothing were the matter. If such a patient be hypnotised, for example, and the hypnotic suggestion strongly made that the paralysed member has recovered strength, the patient will use it freely. Or, if the patient be profoundly etherized, the paralysed part will be forcibly moved when the effects of the anaesthetic are wearing off. In both instances, the patient may remain perfectly well, or may relapse into the former condition. Or a sudden fright, the most common example, may cure instantaneously a paralysis that has existed for years. These and like examples seem to me to prove that the cortical motor cells are not affected, even functionally, for the agents which affect the cure are applied in each instance, not to the cortical motor area, but to the higher volitional centers.

Now, in all the more complicated movements, leaving out, of course, such simple, practically automatic ones as walking for example, the stimulus to the motor centers comes from certain higher brain centers. To illustrate: we may be reading and have suggested by what we read a

desire for food or drink, and we decide upon the character of the object desired and when and how it can be obtained, and then those motor cells are stimulated, which produce the movements necessary for the attainment of our desires. What the nature of this stimulus is, how a pure volition sets into action certain muscles is to us, as it was to the philosophers of ancient times, a mystery. We can only say that in certain regions of the brain, say the frontal area, there are cells which are probably the centers of the higher mental processes; a volition originating in these cells possibly from acquired knowledge or experience, together with certain deductions drawn from such facts finds its agents in the motor cells and communicates with them; in other words the frontal cells are stimulated and in turn stimulate the motor. We know from the histology of the brain cortex that the relationship between the cortical cells in different parts of the brain, in fact between ganglion cells throughout the whole central nervous system is very intimate. Now suppose the connection between the frontal and Rolandic region be broken: we would still have reflex action, but no voluntary movement, according to our theory. Suppose, again, that the cells in the frontal region, the higher centers, were exhausted, were no longer able to send a stimulus of sufficient strength to provoke a discharge in the motor cells; we would have the same conditions as above; reflex preserved, nutrition of muscles preserved, certain involuntary or purposeless movements preserved, and all decidedly voluntary purposive movements lost. This, as we shall see later, will conform to the symptomatology of hysterical paralysis. Now as to the causes that might bring about such a condition in the cells of higher mental functions. We know that repeated calls upon nerve cells exhausts them. We see this illustrated in many ways. Long continued mental exertion will bring about a condition of exhaustion such that all further attempts at mental work are useless until the cells

have rested, recuperated. Practically we know from recent work in this direction (Hodge) that continued stimulation of a ganglion cell by the electric current produces a condition of vacuolation, and actual loss of protoplasm in the cell. Now, what are the most potent causes in the production of hysteria? Space permits the mention of only the most prominent. Bad training in childhood, over indulgence, sudden fright, change from a luxurious to an humble mode of life, sexual excesses, religious excitement, such and like conditions are the strongest etiological factors in the production of hysteria. Hard regular mental work is rarely an exciting cause. It is abnormal mental stimulus, just the sort of causes to produce most readily, exhaustion of the higher centers. In addition to this physiological element, certain general conditions contribute to the production of this affection. Any state of the system which lowers the general nutrition, must exert a strong action upon the nerve centers, so we see hysteria often in the course of certain general conditions as tuberculosis and gout. Undoubtedly anæmia plays a prominent part in the production of hysteria, as does possibly vaso-motor spasm of reflex origin. We see that the higher centers are in such a condition of exhaustion, or perform their functions so feebly that under ordinary circumstances they are unable to stimulate the motor cells to a degree sufficiently high to produce in them a motor discharge. When these higher centers are suddenly and powerfully stimulated, as by some unexpected emotion they may in turn stimulate the motor centers sufficiently to produce normal voluntary motion. The pathogenesis of hysterical paralysis according to the theory proposed, might be expressed thus: certain abnormal stimuli, or usual stimuli acting to an extraordinary degree, produce in the higher centers a condition of exhaustion such that these higher centers are no longer able to stimulate the lower or motor centers to a degree sufficient to produce a discharge.

Did space permit, certain other well known phenomena of hysteria, such as anaesthesia, contractions and the like, could, it appears to me, be sufficiently accounted for on the hypothesis given above.

Hysterical paralysis may come on gradually, the affected parts becoming progressively weaker, or suddenly following a violent hysterical seizure. In this latter class of cases it is necessary to make a differential diagnosis between the hysterical manifestation which precedes the paralysis and true apoplectic coma. This is usually not difficult, though occasionally cataleptoid states may bear a rather close resemblance to apoplexy. In this connection may be mentioned those cases of what Charcot calls traumatic hysteria. An hysterical individual receives a slight injury, which is followed by marked and sometimes prolonged paralysis. I have seen a number of cases of such injury or other painful affection leave behind an hysterical paralysis, as a case recently under my care, in which the patient had a gonorrhœal rheumatism affecting one leg, genuine at first, but afterwards passing into a condition of hysterical paresis, with pain on movement.

The varieties of hysterical paralysis are many; probably the most common is paraplegia. Hemiplegia is not uncommon, particularly following marked hystero-epilepsy. A number of cases of paralysis of all four limbs have been reported. Another curious form is that known as alternate paralysis, affecting the arm on one side and the leg of the side opposite. A very well marked case of this latter variety is to be found in the writings of Hippocrates. Then we may have monoplegia, or even paralysis of groups of muscles only. With any of these may be associated certain other phenomena, particularly hysterical aphonia; also certain visceral paralysis, bladder, rectum, æsophagus, etc. In most instances we find, in addition to the motor affection, derangement of sensibility, more or less. pronounced.

The paralysed side will often be found to be anaesthetic, and this is particularly true of contractions, which so generally accompany the paralysis. These complications were well illustrated in a case seen in Baltimore county not long since. The patient, a woman about 35 years of age, gave a history of paralysis, of a paraplegic type, which had existed for seven or eight years. The right leg was powerless, the leg flexed almost at a right angle with the thigh, and the whole right side completely anaesthetic.

Hysterical paralysis may be of all grades, from a slight paresis or hardly appreciable loss of power to absolute inability to move the part. Most commonly we see paralysis of certain movements of the limb only. For example, in hysterical paraplegia the patient will be totally unable to walk, and yet when lying down may be able to move the legs with freedom, and to exert a considerable amount of force in various directions.

The all important question is the differential diagnosis. It is exceedingly important to bear in mind the fact that hysteria is very apt to appear in persons who have an organic lesion of the nervous system, central or peripheral. I have seen very marked cases of hysteria, with contractions, paralysis, etc., in the course of multiple sclerosis and other cord lesions. The fact that a patient has some organic disease of the nervous system predisposes to hysteria. The danger is that the unquestioned and obvious hysterical symptoms may distract the attention from the symptoms of organic disease present, or that these latter may be included along with the former under the diagnosis of hysteria. Such mistakes in prognosis are not unfrequently made in this way. Then again the mimicry of hysteria is often so perfect that most careful observers are deceived. We have seen that it will not do to rely upon the general hysterical condition which may be prominent in any individual case. Of course this is of great value, and should be always sought for; yet the very generally accepted ideas concerning the hyster-

ical state may prove a stumbling block. It is by no means necessary to have pronounced emotional instability. A person may have hysterical paralysis, and yet show very few or perhaps no distinct symptoms of mental hysteria, except the weakened volition, and this is often not brought out by superficial examination. It becomes necessary then to distinguish between organic and hysterical paralysis upon other grounds than the mere recognition of general hysterical symptoms. One prominent difference is in the seat of the paralysis. We often see parts affected in hysterical paralysis that would require an almost impossible organic lesion to account for. We may have an arm on one side and leg on the opposite, or all four limbs afflicted. A very irregular paralysis should always be looked at with the idea of its being hysterical, unless certain marked organic symptoms show themselves, as in cases of widespread neuritis. Then a very characteristic symptom of hysterical paralysis is its tendency to shift its position; the part first affected recovering, and paralysis appearing in another place.

In hysterical hemiplegia it is to be noticed that the face is almost never attacked, and also that the gait of such a patient differs from that of an organic hemiplegia; in the latter instance the patient looks at the affected limb and at the floor when walking, and the paralyzed limb is swung outward, making the arc of a circle; in the case of the hysterical hemiplegia the patient never, or rarely looks at the affected limb or at the floor, and the boot is dragged without any attempt at rotation. In hysterical paraplegia, as has been mentioned, the limbs can often be freely moved when the patient is in the recumbent position. Monoplegias and partial paralyses of hysterical origin imitate closely those from cortical disease. They are usually less complete, and their mode of onset is different.

The important points to be observed in making the differential diagnosis be -

tween organic and hysterical paralysis are that in the latter, knee-jerk is never lost and generally, slightly exaggerated, the nutrition of the muscles as a rule, is preserved, and the electro-contractility practically unaltered. One symptom that I regard of great negative value is the absence of ankle clonus in those cases in which it should be found, were the cases of organic origin. Certain authors claim that this symptom may be present in hysteria, but genuine ankle clonus must be certainly very rare in purely hysterical cases. The very usual association of anaesthesia with hysterical paralysis is a symptom of importance. It is very common to find hæmi-anaesthesia associated with hemiplegias and also paraplegias of hysterical origin. It is rare to find any affection of speech in hysterical paralysis, other than aphonia, which is very common. This is due to a greater or less degree of paralysis of the vocal cords, which, as shown by the laryngoscope, is always bilateral. The cords do not approximate each other sufficiently. Other forms of paralysis of hysterical origin, such as paralysis of the oesophagus, rectum and bladder are met with, but are of rare occurrence.

It is well to bear in mind that even after the diagnosis of hysterical paralysis has been correctly made, it does not always follow that the case can be speedily cured, for now and then, cases are met with that resist all treatment. Then it is not improbable, as in the oft quoted case of Charcot, that which was originally functional may become organic. Cases of undoubted hysterical paralysis have been reported, in which after a time there has been muscular atrophy. It is often well to put the patient through a course of tonics. There is often enough anaemia to call for iron. A combination that I have found useful, though it probably undergoes some chemical substitution, is bromide of potash and tincture of the chloride of iron. In the pronounced cases the bromides alone are

not of much value except as soporifics. One of the most formidable obstacles met with in the treatment of these cases, especially if the patient be a young girl, is the girl's mother, and it is frequently necessary to begin the treatment on her. It is very hard to persuade the average mother that the symptoms are functional merely, and she will often spoil months of careful treatment by a few injudicious words. For this reason it is sometimes absolutely necessary to take the patient away from home for treatment. As has been pointed out, the cause of hysterical paralysis is probably in the higher brain centers, consequently efforts at cure must be directed toward the centers. The plan of threatening and frightening a patient out of her unfortunate condition will be successful in only a very small per cent. of cases. They are told so often to exercise their will power, the very thing they cannot do, that they get sick of the very word and utterly discouraged with their failures. In a small number of cases a cure may be affected suddenly, sometimes accidentally, sometimes intentionally. In these cases it would seem that the higher centers were not greatly exhausted, and needed only some unusual stimulus to set them in action again. This may be done by anaesthetising the patient deeply, and as the effect of the anaesthetic is wearing off make them walk or use the paralysed part. The same thing may be better accomplished in good subjects by hypnotism. Many of these sudden cures like sudden conversions are extremely liable to lapse into their former condition. We have learned a valuable lesson from the many experiments that have been made with hypnotism in the line of systematic suggestion. This it seems to me is the secret of success in the treatment of many of these cases. In this way the will power is gradually led back to its former commanding position. While the brilliant results of the plan of treatment advocated and practised by Playfair and Weir Mitchell are in part due to enforced rest, feeding and passive exer-

cise, without doubt an important element is the suggestive one, the gradual cultivation and strengthening of the higher, volitional centers.

The first steps in the treatment is to make the patient feel that the physician has absolute control of the case, that there is no appeal from his decision. It is usually not a difficult thing to gain the confidence of your patient, and this confidence should never be abused. It is a very bad plan to discuss such patients, or to hold up a threat, which the patient knows full well will never be put into execution. If possible the physician should never take a position from which he is likely to be compelled to recede. After proper attention to general or special conditions, that is to say tonic treatment if necessary, relief of dyspeptic or uterine trouble, the patient should be put upon a system of rigid training. As has been said this is often impossible at home. Food, sleep, exercise &c., should be ordered regularly, and the order strictly enforced. If the patient cannot sleep the required time she should remain quietly lying down. Then the special treatment to the affected part should be vigorously applied, and in the most suggestive manner. The paralysed member should be exercised daily, or better twice a day by moderately strong Faradic currents, systematic massage applied and the patient encouraged to use the affected part. Such attempts should be encouraged, and the suggestion constantly made that improvement is going on. Sometimes it will be necessary to isolate the patient from all friends, at other times pleasant company and some mental occupation will succeed best. In all cases the efforts should be persistent. If an hysterical patient improve decidedly and then fall back, it is like a person who had climbed to a considerable height np a ladder, the higher they are when they fall, the harder the fall will be. Some of the worst cases I have ever had to treat are those that have improved a good deal and then slipped back. Often it would seem that the

rigid discipline and the tedium of the treatment, force the patient to relent, but the fact is that the will-power is gradually stimulated in this way, and what seems like the discontinuance of a farce, is in reality a successful effort to set the mental machinery to work again. Usually the cure comes about by slow degrees: first, a vigorous attempt to move the paralyzed part: then slight irregular movements which increase sometimes very slowly, sometimes quite rapidly to perfect motion.

In hysterical aphonia the strong Faradic current, either in the form of a wire brush, or if necessary a laryngeal electrode will rapidly bring about a cure. The following case will illustrate the plan to be pursued: Miss M., general hysteria and almost absolute loss of voice. It was necessary to put the ear close to her mouth, and then many words were lost. Articulation was very indistinct and slow. I impressed on her the effect that the battery would accomplish for one or two visits before applying it, speaking confidentially of the cure. I then applied an uncovered electrode to the outside of the larynx and used a painfully strong current, urging her to speak, and steadily increasing the strength of the current. After a few applications her voice came back naturally, though she had not spoken aloud for probably two years, and in the year or more that has intervened since I saw her, she has had no return of the trouble.

In conclusion I would call attention to the great value of hydro-therapy in the treatment of these conditions. It is well to begin with a very slight douche of moderately cold water to the spine every morning, and increase it until the patient can take a pitcher full of cold water down the spine or a general cold sponging. The cold water should not be applied to the head. The plans which have been found most useful in the treatment of the various forms of hysterical paralysis have been here only briefly indicated, space not permitting any elaboration of them. The intellec-

tual condition and mental habits of each individual patient must be carefully studied before any intelligent treatment can be employed. It is very necessary that the physician who is called upon to treat this class of diseases should cultivate, if he do not already possess, the virtue of patience, that he should be sure of his diagnosis, and confident of the success of his mode of treatment.

9 East Preston Street.

A SUCCESSFUL CASE OF LITHOTOMY ON A PATIENT WHO
WAS TAKING, DAILY,
120 GRAINS OF
MORPHIA.*

BY NATHAN R. GORTER, M. D.,
OF BALTIMORE.

On the 17th of April, I was called to the Eastern Shore of Maryland, in consultation with Dr. Brice W. Goldsborough, of Cambridge, and Dr. James T. Jacobs, of New Market, to see a patient who for many months had suffered with intense pain in his bladder. His physicians, who had recently been called to attend him, urged that I be sent for, with the hope that a permanent perineal fistula might be made, from which he would get some relief. Upon my arrival at Cambridge on the morning of the 18th inst., a telegram was received which stated that the man was sinking, and unless quickly relieved he would die. Dr. Goldsborough and I drove at once to New Market, a distance of twelve miles, where our patient resided.

The history of the case as given by the patient, Mr. J. M. T., is as follows:

In 1881, he had an attack of nephritic colic. In 1882, Dr. Alan P. Smith, of Baltimore, performed lithotomy upon him, after which he passed a great deal of sand, and was relieved. In 1884, he

*Read before the Clinical Society of Maryland May 16th, 1890.

had another attack of kidney colic, passing the stone through the urethra. In 1886, he again had passage of stone from kidney, which also passed out through the urethra. In 1886, he had his last attack of renal colic, but while not remembering to have passed the calculus, he was certain that no stone was in his bladder, because he did not feel as he did before Dr. Smith operated, and because he had been sounded and no stone found.

For the past year or eighteen months, his pain had been so intense that he had been compelled to resort to morphia for relief. He commenced the use of morphia March 25th, 1889; by the middle June, he required two grains a day, and continued with this amount until the first of September, when his pain became greatly aggravated, and he was forced to take from 20 to 40 grains a day until the end of the year. From January 7th to March 3rd, 1890, he consumed one to two drachm-bottles of sulphate of morphia a day, containing 57 grains each; at times, when the pain was less severe, only twenty grains were taken; other days 100 grains were required to keep him quiet, and at the time of the operation he was taking 120 grains a day. These facts were obtained from the druggist who dispensed the morphia, the nurse, and the patient himself. Dr. Jacobs, of New Market, saw the patient take 32 grains in half an hour, with the effect of barely quieting the pain.

I examined the patient in the presence of Dr. Brice W. Goldsborough and Dr. Thomas B. Steal, of Cambridge, and Dr. James T. Jacobs, of New Market. Finding the urethra and bladder too sensitive to admit of the introduction of a sound without the use of an anæsthetic, I requested Dr. Jacobs to administer chloroform, and upon introducing a Thompson searcher, I at once struck a stone. There was no enlargement of the prostate, but the bladder was found to be contracted and thickened. I immediately decided to do lateral lithotomy.

The patient was put in the lithotomy position, Dr. Jacobs continuing to administer chloroform; the right leg was held by the nurse, the hand and foot having been tied together; the left leg was held by Dr. Steal, of Cambridge, but in that case the tying had to be dispensed with, as our man had lost his left arm.

The operation was performed with a Smith lithotome, Dr. Goldsborough holding the staff for me, and a calculus weighing 100 grains and composed of a phosphate of lime nucleus, with a uric acid periphery was quickly removed. On the following day, April 19th, the pulse and temperature were normal, and the pain greatly relieved, the only unfavorable sign being subsultus tendinum. Finding that only two grains of morphia had been given every two hours since the operation, and believing the subsultus due to this fact, the dose was at once increased to four grains every two hours; and, in addition to milk and liquid beef peptonoids and moderate doses of whiskey, which were being administered, 30 drops of tincture of musk, every four hours, was ordered.

After the first dose of musk, which was given the following morning (April 20th), the patient slept for four hours, which was the longest unbroken sleep he had had for a long while.

April 21st the patient was in a state of collapse, and had been so since the afternoon previous, with almost complete suppression of urine.

Turpentine stapes were freely applied over kidneys, and large doses of carbonate of ammonia, with musk and digitalis, were given. The patient rallied, and from that time, with only occasional attacks of prostration, has been slowly getting well, and he is now (May 16th, 1890), up and about his room.

There has been no fever since the operation, and the urine has passed naturally since the 15th day. The morphine has been gradually reduced, until at the present time only ten to fifteen grains a day are taken.

Society Reports.**MEDICAL AND CHIRURGICAL
FACULTY OF MARYLAND.**

*Ninety-second Annual Session, held at the Hall of the Faculty, Baltimore,
April 22, 23, 24 and
25, 1889.*

DR. AARON FRIEDENWALD, PRESIDENT,
IN THE CHAIR. DR. G. L. TANEYHILL,
ROBERT T. WILSON AND WILLIAM B.
CANFIELD, SECRETARIES.

TUESDAY, APRIL 22ND.—FIRST DAY.

The ninety-second annual session of the Medical and Chirurgical Faculty of Maryland was called to order at the Hall of the Faculty, corner St. Paul and Saratoga streets, April 22nd, at 12.30 o'clock, P. M. The President, Dr. Aaron Friedenwald, in the chair. After reading the minutes of last meeting by the Secretary, Dr. Aaron Friedenwald delivered

THE PRESIDENT'S ADDRESS,

on the subject of

THE MODERN HOSPITAL.

(See page 1.)

At the conclusion the speaker was loudly applauded, a vote of thanks was passed, and his address was requested for publication.

THE LIBRARY COMMITTEE

reported that 246 books had been added to the library, making 6,720 on the shelves; 100 volumes of journals had been bound. Many books and journals had been presented by individuals and publishers.

THE MEMBERSHIP COMMITTEE

reported that they sent out 1,500 notices of the Hagerstown meeting, and had received the names of over 100 candidates, most of whom would be added to the Society.

**WEDNESDAY, APRIL 23RD.—SECOND
DAY.****THE ANNUAL ORATION**

was then delivered by Professor Joseph Taber Johnson, A. M., M. D., Ph. D., of Georgetown University, Washington, D. C., on

ABORTION AND ITS EFFECTS.

(See page 21.)

Upon motion of Dr. Wm. T. Howard, a unanimous vote of thanks was tendered to Dr. Johnson for his very timely and interesting address, and a copy requested for publication in the transactions of the Faculty.

SECTION ON SURGERY,**CHAS. G. W. MCGILL, M. D., CHAIRMAN.**

Dr. C. F. Bevan read a paper entitled

HYDATID CYST OF THE LIVER (SUPPURATIVE); OPERATION, AND RECOVERY.

(See page 41.)

Dr. J. W. Chambers related a series of

CASES OF HEAD INJURY,

and *Dr. S. T. Earle* read a paper on

OPERATIONS FOR HÆMORRHOIDS.

In the

DISCUSSION

which followed,

Dr. Wm. H. Welch, in referring to Dr. Bevan's paper, said he had seen about half a dozen cases of hydatid cyst of the

liver in this country. The books give the impression that the disease is of everyday occurrence. It does occur. He had found it in a number of pigs, and in three instances he traced the disease and found that two of the pigs got it in this region. It comes from dogs. He had examined the intestines of a large number of dogs, but had not found the *tænia echinococcus*. This is not wonderful, for it is very minute. Most of those are when the dog has been fed for it. The two points in diagnosis are that it is possible to make a diagnosis by the microscopic examination of the fluid withdrawn, containing the membranes and characteristic hooklets. Also, it is possible to arrive at a very probable diagnosis by a chemical examination of the fluids, which usually contain no albumen.

SECTION ON PRACTICE OF MEDICINE,

GEORGE J. PRESTON, M. D., CHAIRMAN.

Dr. Preston read a paper on

THE NATURE AND TREATMENT OF HYSTERICAL PARALYSIS.

(See page 67.)

SECTION ON OBSTETRICS AND GYNAECOLOGY.

B. B. BROWNE, M. D., CHAIRMAN.

Dr. Browne read a paper on

THE REMOVAL OF SUBMUCOUS AND INTRAMERINE FIBROID TUMORS BY ENUCLEATION AND TRACTION, WITH REPORT OF TEN CASES.

(To appear later.)

Dr. R. M. Hall read a paper on

FIBROID TUMORS COMPLICATING PREGNANCY.

(See page 50.)

Dr. L. E. Neale exhibited

A DOUBLE MONSTER,

belonging to the class of terata kata-didyma of the kind *diceranus* and *diprosopus*, which had been presented by Dr. George A. Fleming. It was from a multipara. Dr. Fleming had made a digital examination, and feeling between the two heads, had very naturally diagnosed a breech presentation. The child was born, and the two heads appeared, revealing the true condition. It is of interest to note that both heads cried at once after birth. It lived a few minutes, then gasped and died. Dr. Neale also exhibited a case of *acardia* and *acephalus* occurring in his own practice.

In the

DISCUSSION

which followed,

Dr. B. B. Browne, in referring to a case of failure in Cæsarean section, referred to by Dr. Hall, said that the idea was to perform the section, but as the pulsation in the cord had ceased such a thing was out of the question. Still, it was well to keep such cases in view, and be ready for the operation to be done at any time.

Dr. R. M. Hall referred to a case of a single woman, a primipara, who gave birth at the seventh to eighth month to a monster with the cleavage from below. When he reached the house it was born. The specimen was examined by Dr. Councilman, who found two cords and two membranes.

Dr. L. E. Neale had a case which he was not able to exhibit. A colored woman gave birth to her first child, whose upper extremities were much like the flippers of an amphibious animal. She said she had been in the habit of going to the park and watching the sea-lions; but on further questioning her she said she did not go to see the sea-lions until in her fifth month, and if there is anything in the theory of maternal impressions, which Dr. Neale was inclined to doubt, the im-

pression should be made in the first eight weeks to affect the fœtus. He had not much faith in maternal impressions.

THIRD DAY, THURSDAY, APRIL 24TH.

SECTION ON MATERIA MEDICA AND CHEMISTRY,

C. H. JONES, M.D. CHAIRMAN.

Dr. E. F. Cordell read a most excellent résumé of the

THERAPEUTICAL PROGRESS IN 1889.

(See page 61.)

In the

DISCUSSION

which followed

Dr. P. C. Williams spoke of the difficulties of finding a reliable hypnotic, especially in cases of hysteria. Sulphonal is slow and uncertain, and fails in hysterical cases, although it is good in mere wakefulness. He endorsed what was said about chloroform. Do not put a patient under it too gradually. The best inhaler is a cylinder. He gives chloroform chiefly in labor, and then uses it whether the heart is affected or not. Its use prevents unnecessary strain on a diseased heart.

Dr. J. D. Blake thought the danger of chloroform was at the begining. The nervous system should become gradually accustomed to the chloroform.

Dr. C. H. Jones thought the Hyderabad Commission had shown nothing new in its investigations.

Dr. J. J. Chisolm has fought the battle for chloroform for twenty years. The Hyderabad Commission has sustained every point he had made.

Dr. A. K. Bond thought the pupil should be watched in chloroform anæsthesia. This was more important than the pulse or respiration.

Dr. Hiram Woods said there was no use in watching these signs. Some have a susceptible heart and will die anyhow.

Dr. I. E. Atkinson thought the skill of the anæsthetizer should be taken into account.

Dr. J. W. Chambers thought the amount and method of giving it made very little difference. Some die anyhow.

Dr. L. McLane Tiffany said neither chloroform nor ether was the best. The medical man should confine himself to neither, exclusively and use his judgement and discretion.

Dr. George H. Rohé thought the cases should be selected.

Dr. C. G. Hill gave chloroform at first and followed it up with ether.

This paper was further discussed by Drs. W. R. Monroe, J. H. Branham, J. E. Michael and R. Winslow.

SECTION ON ANATOMY, PHYSIOLOGY AND PATHOLOGY.

HERBERT HARLAN, M. D., CHAIRMAN.

Dr. John C. Hemmeter gave

A RÉSUMÉ OF THE LITERATURE ON
SO-CALLED TROPHIC NERVES.

(To be continued.)

The Second Annual Meeting of the American Pediatric Society will be held in New York, June 3rd and 4th, 1890, at Mott Memorial Hall, Madison Avenue and 27th Street.

Dr. George Reuling, Professor of Diseases of the Eye and Ear in the Baltimore Medical College, has been appointed by the B. & O. R. R. as Oculist and Aurist of their employees between Philadelphia and Washington, including the employees in the cities of Baltimore and Washington.

Dr. J. M. Anders has been transferred from Diseases of Children to Clinical Medicine, *Dr. Ernest Laplace* made Professor of Pathology and Clinical Surgery, and *D. Samuel Wolfe*, Professor of Physiology, in the Medico-Chirurgical College of Philadelphia.

MARYLAND MEDICAL JOURNAL

Weekly Journal of Medicine and Surgery,

WILLIAM B. CANFIELD, A.M., M.D., Editor

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BALTIMORE, MAY 24, 1890.

Editorial.

THE RATIONAL TREATMENT OF SUMMER COMPLAINT.

The fact that so many children fall a victim to diseases of the gastro-intestinal canal during the warmer months, has in the more recent history of medicine, caused a more scientific study of these diseases.

The almost hopeless task of classifying the intestinal bacteria in children has only been undertaken in the more recent years of bacteriological interest, and yet such men as Escherich, Booker, Holt and others have succeeded in bringing a glimmer of order out of this chaos.

The practical results of their work has, in some cases, explained the former

method of treatment discovered by empiricism, in other cases it has suggested a new line of treatment based on chemical or other grounds.

Dr. B. K. Rachford (*Archives of Pediatrics*, June 1890), thinks that disappointment will follow the dietetic treatment as laid down in most text books, as summer complaint embraces such a varied array of symptoms, and each case is a law unto itself.

The chief causes of summer complaint are abnormal intestinal fermentations, both acid and putrid. In the former case an albumen is indicated, in the latter a carbohydrate. The treatment according to the acidity or alkalinity of the stools as suggested by Escherich, or by the odor as laid down by Christopher, is theoretically simple, but practically it does not always give the expected results.

According then as a case is caused by the fermentation of albuminous material or carbohydrate, we may formulate the following rules:—

1st. Avoid albuminous food (a) when marked constitutional symptoms are present; (b) when in doubt as to the character of the fermentation causing the disease; (c) when the stools are putrid; (d) when the stools contain mucus and blood; (e) when the nausea is constant and not relieved by vomiting.

2d. Avoid carbohydrates as a food (a) when there are no marked constitutional symptoms present and the stools are continuously acid; (b) when there is much flatus, pain, or urticaria.

3d. When the albumens are to be avoided the carbohydrates are, as a rule indicated; and when the carbohydrates are to be avoided, the albumens are, as a rule, indicated.

4th. Give foods such as cream, beef broths, and whiskey (*a*) when the foods prescribed according to the above rules disagree; (*b*) during the first twenty-four hours in severe acute cases; (*c*) when in doubt as to the character of the food indicated.

These rules are not infallible, but they are founded on sound principle. Milk is contraindicated in the more serious cases, and in convalescence it should be given well diluted so that its albumen and sugar may be digested and absorbed before reaching the seat of the disease in the small intestines.

Therefore, give an antiseptic cathartic such as calomel, stop the milk and all other food except such as are directed above and then proceed according to the rules laid down and success will be more frequent in the management of these cases.

THE DEFEATED MEDICAL BILL.

The recent editorial containing more facts than poetry, which told the truth about the defeated Medical Bill, has excited interest both at home and in other states. The Cincinnati *Lancet-Clinic* says: "The Riot Act was very forcibly read by the editor of the *British Medical Journal*, in the issue of May 3, to Lord Wolseley, Commander-in-Chief of the English army, for his attempt to degrade and lower the standing of the medical staff of the army. In a similar manner the editor of the *Maryland Medical Journal*, in the last issue of that publication, utters a criticism of the Governor of that State for his refusal to sign the medical act that had been passed by the Legislature. The effect of such assertions of

the inalienable rights and claims of the medical profession for just recognition on the part of government authorities must and will, in the very nature of things, have a salutary effect."

Correspondence.

SANITARY INSPECTORS.

Editor Maryland Medical Journal:

DEAR SIR:—In reply to your letter in issue of May 10th, signed "I," regarding the notification of infectious diseases and Sanitary Inspectors, I would say that Dr. Wilson's and your experience is of no manner of use whatever.

Do you know that the first qualifications for the position are: 1st, Is the Inspector a Democrat? 2nd, Is he an important man in his ward? 3rd, How many votes can he control? These are questions, Mr. Editor, more important than the qualification of the man. I am sure there are many in the Health Department who could not pass a civil service examination, even for the most humble place there.

Now, Mr. Editor, if such is the case, if we have men as Sanitary Inspectors who cannot write ten lines correctly as per civil service reform examination, is it not natural that the doctors of Baltimore should complain, and is it not also natural that these ignorant men should make such blunders as are charged against them? While we have one of the most scientific men in Baltimore, and one who stands at the head of his profession, a physician of high position and a man eminently fitted for his place, is it not a shame that he should be handicapped by these ignorant political and miserable excuses for Inspectors? If I, as a citizen of Baltimore, had the appointment to these positions, I would appoint only such men as I was convinced were fit for

the position, after careful examination and mature deliberation, and I would appoint none other. If necessary, I would appoint none but young physicians, graduates in the various schools of medicine in Baltimore, and then I would get none but the best; at least I would have much more intelligent and better stock, qualified for the position of Sanitary Inspector, than we now have.

Dr. Robé is the right man in the right place, and it only remains for him to select the right men for places under him, and he will have the model Health Office of Baltimore and of America.

A LAYMAN.

Reviews, Books and Pamphlets.

A New Medical Dictionary. Including all the Words and Phrases used in Medicine, with their proper Pronunciation and Definitions, based on Recent Medical Literature. By GEO. M. GOULD, B. A., M. D., Ophthalmic Surgeon to the Philadelphia Hospital, etc. With Tables of the Bacilli, Micrococci, Leucomaines, etc., of the Arteries, Muscles, Nerves, Ganglia and Plexuses; Mineral Springs of the U. S.; Vital Statistics, etc. Small octavo, 520 pages. Half Dark Leather, \$3.25; Half Morocco, Thumb Index, \$4.25, Philadelphia: P. Blakiston, Son & Co. 1890.

Although a dictionary cannot show its true value until after long and careful use, a glance through this book and the perusal of definitions here and there show that the author has not only done his work carefully, but has given concise definitions without writing an essay on each word. There has been a want felt for a good dictionary of this kind. The tables inserted are an especial feature of the book, and enable one at a glance, to review the whole subject sought for, and are arranged in a manner reflecting great credit on the publishers as well as

the authors. The book is cheap, compact, well bound, easily portable, and will probably be a favorite with physicians and students.

Beitrag zur äusseren und inneren Anwendung des Ichthyols. Von Prof. Nils Osn. Gadde, Director des Krankenhauses in Lund. Sonderabdruck aus Therapeutische Monatshefte. 1890. Heft 3.

Ueber die Anwendung des Ichthyols bei Frauenkrankheiten. Von Dr. H. W. Freund, I Assistant. Sonder-Abdruck der Berliner Klinischen Wochenschrift, No. 11, 1890.

Ueber den inneren Gebrauch des Ichthyols. Von Geheimrath Dr. Von Nussbaum in München. Berlin, 1888.

De l'Ichtyol dans le Traitement de L'Anthrax, par le Dr. Jules Félix, chirurgien à l'Hospice Sainte-Gertrude, à Bruxelles. 1889.

Miscellany.

THE HOT SPRINGS OF ARKANSAS AND THE TREATMENT OF SYPHILIS.

Dr. R. W. Taylor in the *Medical Record* for April 26, 1890, in a paper on the treatment of syphilis, while appreciating the value of the Hot Springs of Arkansas in some cases, says that with increasing care and precision in clinical examinations, and proper adaptation and modification of the dose of antisyphilitic remedies in the treatment of syphilis, and with an armamentarium rich in resources and adaptable methods, the physician will less and less frequently experience the chagrin of having his patients elope to the Hot Springs of Arkansas.

BRONCHITIS.

Dr. Richardson, in *The Med. Summary*, says: For chronic bronchitis I find nothing better than the muriate of ammonia. I usually give it in the following formula:

B Ammonia mur. 2 drachms.
Fl. ext. glycer. 1 drachm
Syr. simplex 3 ounces.
M. Sig: Teaspoonful every two or three hours.

For acute bronchitis in adults I give the following:

B Tinct. opii camph. 1 drachm.
Tinct. aconiti rad. 30 drops.
Syr. ipecac. 1½ ounces.
Mucl. acacia 1½ ounces.

M. Sig: A teaspoonful every two hours.

And for the acute form in children, I prefer the following:

B Ammonia carb. 1 drachm.
Syr. ipecac 2 drachms.
Syr. tolu. 1½ ounces.

M. Sig. One-half to one teaspoonful, according to age.

—*Therapeutic Analyst.*

CURE FOR A COLD.

S. Wilson Hope (*British Medical Journal*), says that twenty grains of salicylic acid, in liq. ammon. acet. three or four times a day, will so far control a common cold that the aching of the brow, eyelids, etc., and pain during movements of the eye, will cease in a few hours, while the sneezing and running from the nose will abate, and will disappear in a few days; and, more fortunate still, the cold will pass off, and not finish up, as is customary, with a cough.

Medical Items.

Mrs. J. Marion Sims died in New York last week.

Dr. Harry Friedenwald has an office at 922 Madison Avenue.

The South Carolina State Medical Association has just closed its annual meeting.

A new Professor of Clinical Medicine is to be established at Munich which will probably be given to Dr. Scheck.

Professor Thiersch, of Leipzig, has been chosen President of the next Congress of German Surgeons.

The German Emperor has given 20,000 marks (\$5,000), towards the erection of a new German hospital at Zanzibar.

Presido del Norte, Mexico, a town of 7,000 inhabitants, is said to be without any resident physician.

Bardeleben is seventy years old, and has performed, it is said, 30,000 operations.

It is said that the people of Boston consumed a ton of quinine during the ten days of the influenza epidemic.

It is said that Paris contains one hundred thousand prostitutes. Only forty thousand of these are registered. Syphilis, etc., is epidemic.

Virchow objects to the term "malaria," as applied to a disease. He says it is rightfully used to indicate the cause of a disease, but not the disease itself.

Dr. W. H. Byford, one of the most prominent physicians in Chicago, and an old resident, died there last Wednesday of heart trouble.

A building is about to be erected in Chattanooga, Tenn., for the use of the medical department of the University. The new college has just completed its first term.

The Street Cleaning Department of New York has appointed three physicians to examine all applicants for positions on the force, to determine whether they are physically fit to do the work required.

The attendance at the forthcoming

International Congress at Berlin, this summer, is estimated to exceed five thousand, and special arrangements will be made in consequence.

The profession of New York is trying to have the unjust law repealed according to which a physician is ineligible for the position of President of the Board of Health of New York City.

Dr. John S. Dorsey, a graduate in Class of 1820, at the College of Physicians and Surgeons, Baltimore, has opened an office at Solomon's, Calvert county, Md.

The Croonian lectures will be delivered at the Royal College of Physicians by Dr. Ferrier, on June 3rd, 10th, 17th, 19th, 24th and 26th. The subject will be "Cerebral Localization."

The Rhode Island Medical Practice Bill has been defeated in the legislature by a vote of twenty-two to eight. The physicians of the State were apparently not very active in support of the bill.

The Chicago Commissioner of Health complains because some physicians do not comply with the law in reporting contagious diseases. He proposes hereafter to prosecute every offender.

Dr. Park of Chicago is said to have received a fee of \$25,000 from a patient in San Francisco for several weeks of attendance, and Dr. Samuel Sexton of New York, received a similar amount for a successful operation in St. Paul, Minn.

An Exchange announces that Dr. I. Minis Hays has resigned his position as editor of the *American Journal of the Medical Sciences*, and that he will be succeeded by Dr. Edward P. Davis, Obstetrician to the Philadelphia Hospital.

The Harford Medical Society met at Belair Md., last week and passed appro-

priate resolutions on the death of one of its members, Dr. Richard D. Lee. The officers elected for the ensuing year were: President, Dr. T. H. Kennedy, secretary and treasurer, Dr. Wm. S. Gorsuch.

The Academy of Medicine (England) announces as the subject for its prize essay for 1891 the best forms of artificial nourishment for new-born infants, merits and defects of unboiled milk, boiled milk and tepid milk. Essays should be sent in before March 1, 1891. The prize amounts to \$400.

Any one interested in the sick-benefit, funeral-aid, and death-beneficiary associations of the United States can help make the statistics of their organizations for the coming census more complete and disseminate the knowledge of the good work they are doing by sending the names of such societies as they may know of, and the addresses of their principal officers, to Mr. Charles A. Janney, Special Agent of the Eleventh Census, 58 William Street, New York City.

The Twelfth Annual Congress of the American Laryngological Association will be held at Hopkins Hall of the Johns Hopkins University, Baltimore, May 29th, 30th and 31st, 1890. The profession is cordially invited to attend these meetings. After the President's address, by Dr. John N. Mackenzie, of Baltimore, papers will be read by Drs. John N. Mackenzie, S. Solis-Cohen, Morris J. Asch, Harrison Allen, Alexander W. MacCoy, Chas. H. Knight, H. L. Swain, E. Eletcher Ingals, S. O. Vander Poel, S. W. Langmaid, Clarence C. Rice, F. H. Bosworth, D. Bryson Delavan, George W. Major, John O. Roe and F. Donaldson.

On Tuesday night, the President, Dr. Mackenzie, will give a reception to the fellows, and on Wednesday night, the annual dinner of the Association will be held at the Rennert.

MARYLAND MEDICAL JOURNAL,

VOL. XXIII. No. 4. BALTIMORE, MAY 24, 1890.

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RECENT PSYCHOLOGICAL PROGRESS.

BY CHARLES G. HILL, M. D.,
OF BALTIMORE.

[Being report of Section on Psychology.]

In consenting to make the report for this Section, on account of Dr. Conrad's illness during the winter, I very much fear that I was more charitable to him than to either this Faculty or myself, thereby falsifying the old saying that charity begins at home. The brevity and poverty of the report, I must in all candor admit is due neither to the lack of progress of this branch of medicine during the past year, nor to the committee to whom was entrusted its compilation, but to your humble servant, who, under

a pressure of other matters, neglected it until to late to do justice to the subject.

Gladly would I recount in detail the rapid strides being made by this division of medical science, and show that, *pari passu* with the others, it is steadily advancing. And nowhere else can be found a more prompt, practical and humane application of the attainments of science, than in the care and treatment of those whose higher faculties are perverted and distorted by disease. Dr. Andrew White, late of Cornell, in his "New Chapters on the Warfare of Science," speaks to the point when he says, "Of all the triumphs won by science for humanity, none have been further reaching in its good effects than the modern treatment of the insane." I hold up this tangible and useful result of psychological advancement because the best standard of measurement for medical science in any of its branches is its capacity to contribute to the welfare of the human race.

*Read before the Medical and Chirurgical State Faculty of Maryland, at its 92nd Annual Session, April 25th, 1890.

But psychological progress has not been confined to the practical alone, but the theoretical and speculative have also come in for their share of attention. As an instance, go with me for a moment into some of the beautiful and intricate theories, from the pen of Dr. Henry Smith Williams, of New York, on the "Molecular Dynamics of the Encephalon." Assuming, as an anatomical fact, that each pyramidal cell of the cortex cerebri is made up of fibrils, with a surrounding matrix of nitrogenous matter, and that these cells seem to be built up out of other nervous tissue, and have fibrils entering and issuing from them, and that it would seem, *a priori*, probable that their structure is likewise fibrillar, therefore, without other experiment, except that the latest direct observations are confirmatory of this supposition, he proceeds to the elaboration of what is called the "vibratory theory of mind," and concludes that the "mind is an organism engendered transmutation of the forces of the environment, and as completely and rigidly dependent upon these forces as is any other effect upon its cause." He believes, in accord with the teachings of modern physics, that each and all of these forces come to the organism as forms or modes of motion, and hence may be associated in their incipiency as vibrations. These vibrations he considers of unknown form and infinite number. Says he, "Vibrations of heat, light, magnetism, electricity, and perchance a thousand other known or unknown forces, are beating upon all portions of the organism, and each one is caught up by a peripheral nerve element and transmitted to a common centre. Each channel of such transmission is demonstrably a delicate fibril, and it can scarcely be doubted that the transmutable force as it travels along this wire is still made manifest in a vibration of matter. But just what particular form of vibration is here involved is not, by any means, so easily settled. Doubtless it has many points of resemblance to electricity, but various considerations,

among others its comparative sluggishness, make the idea of identity untenable. Most probably it is a condition, *sui generis*, a transformation of electricity, light, heat, sound and other forces, yet in itself neither one nor the other of these. Once caught up or evolved by the peripheral nerve elements, it is transmitted along well-known afferent tracts till it reaches its central destination in the cerebral cell. A purely physical, and, in a sense, comprehensible, vibration we follow it to this point, but here, in the midst of those highly evolved organic tissues, we are at the very border line of the material, and it seems as if, could we take one further step, we would open tangibly the nature of the spiritual. Our vibration quivers in the labyrinthine cells of the cortex, a physical vibration still; and then, of a sudden, it has flashed beyond our ken, and reappears, as if beyond a bridgeless chasm, transformed into a new entity, a sensation of consciousness. Why flashed it there? Why must we fail to follow it? Why is it changed, nay, metamorphosed, into consciousness?"

Doubtless it would be interesting to follow the learned writer further into this prolific field of inquiry,* but my object in quoting so much of his paper is to show that psychological progress is not measured by the advancements in cerebral localization, and the application of new remedies by which troublesome nervous manifestations may be tamed and subdued, but in its scope it reaches out into the metaphysical and subtle relation of mind and matter, and boldly invades the obscure and delicate realms of consciousness, will and memory.

But, to return to the practical, probably no subject has received more careful study in all its details and made more rapid progress, than that of cerebral localization. This has carried with it a better general knowledge of cerebral anatomy, psychology and pathology, and deeper research into the functions of the cortex of the brain, by the means of

*Refer here to the author above quoted and to Charles Mercier.

physiological experiment and chemical observation. The result of the late advances in crano-cerebral topography has already been made manifest in the recent wonderful development of brain surgery—the demonstration of the possibility of locating and removing brain tumors and delicate portions of brain, constitutes one of the greatest advancements of modern surgery, and the brilliancy of this discovery shines with at least reflective light on the department of medicine which is now under consideration. It would consume too much of your time to attempt any detailed review of the advances in cerebral localization, and I shall confine myself to a very brief summary of what has been recently done in this line.

The location of all mental functions in the cortex, if this assumption needs further verification, is negatively proven by the fact, as recently shown, that atrophy of the cortex is a constant concomitant of an advanced mental disease. In only six out of sixty-eight autopsies made at the Boston Lunatic Asylum by Dr. W. W. Garnett was there lack of evidence of some degree of atrophy of the cortex. In these six cases the patients died of some fatal organic disease intercurrent with the insanity. In two of these there was extensive pachymeningitis; in one, external exostosis of the skull; in one, great anaemia of the brain; and in the last, general tuberculosis. In each case the patient died before insanity was fully developed, and no doubt atrophy would have occurred sooner or later. In five of the six cases there was a lesion which affected the cortex generally, and in only one case was there an apparent exception to the rule, and this was the case of general tuberculosis.

Admitting that many forms of insanity are functional in their earlier stages, and hence curable, I beg leave to insist that a diseased mind means a diseased brain, and to emphasize the foregoing figures for the sake of those who persist in locating nearly all cases of insanity in the uterus and ovaries of the female, or

sexual apparatus of the male. But advancements and achievements in this line by no means stop with the location of the seat of the lesions of insanity in the cerebral cortex. Since M. Broca, to whom is due the honor of being the pioneer in this line of investigation, first pointed out that the motor centres of speech were located in the posterior third of the third left frontal convolution, more than half the cortex has been distinctly mapped out with a score or more of centres of movement or sensation. This has been accomplished more by physiological experiment than by the study of lesions affecting the cortex. We call these localizations motor and sensory centres, but they are really centres of ideation. The mental operations are in a great part connected with sensory and motor phenomena, and are so completely represented in the regions described that it is hard to imagine just what functions the unassigned portions of the cortex can represent. Stimulation of the enclosure is negative in its results. Generally speaking, the anterior half of the frontal lobes, the posterior portion of the occipital lobes, and the basal surface of the two hemispheres, constitute the true "terra incognita" of the cortex, and would we not be justified in locating by exclusion, in this otherwise unaccountable region, the higher centres of mental action?

I cannot close this desultory report without allusion to the valuable addition that has been recently made to the list of therapeutic agents, adapted to the relief and cure of mental and nervous disorders and diseases. These are divisible into three heads:

1st, Those derivatives of coal-tar, whose principal effects are to cause a lowering of the animal temperature and antisepsis.

2nd, Those of the ether series of compounds which have an anaesthetic and hypnotic action when inhaled or otherwise introduced into the system.

3rd, That important and very different group of complex organic composi-

tion—the so-called active principles of vegetable life.

The first group embracing the now well known antipyrine, antifebrine, phenacetine, etc., I will pass by as being not directly in the line of our inquiry.

To the second, or ether series, we are indebted for many valuable remedies, to some of which I will briefly invite your attention. The first place on this list, I unquestionably give sulphonal, the very queen of hypnotics. The almost universal report of this agent is that its very effect is the important one of increasing and prolonging the natural tendency to sleep; that its action is not narcotic, but purely hypnotic; that the pulse, pupils, temperature, respiration, appetite and the secretions remain practically unaffected after its daily use for indefinite periods, and that it is promptly eliminated from the system, principally by the kidneys, without irritation or detriment to these organs. It is slower in its action than chloral, but more prolonged, and its constant use does not weaken its physiological effect, nor does it produce the desire for a narcotic, that makes chloral and other drugs so dangerous. It is claimed that it does not affect the heart-action, but I believe my experience with it justifies me in going further, and saying that it does affect it, favorably. I am satisfied that it increases arterial tension, being thus beneficial to the weak and depressed patient, and I have never seen an instance of heart failure when sulphonal was freely administered. Much more might be said in praise of this wonderful agent, but I must pass on to others.

Of *chloralamide*, I cannot speak so favorably. It is generally efficacious in doses of 15 to 75 grains, but in many cases it fails entirely where chloral succeeds in smaller doses. It frequently causes severe headache, loss of appetite and drowsiness, and does not seem to possess any decided advantage over many other drugs of its class.

Urethan, like sulphonal, does not depress the heart, and is said to notably

increase the amount of oxygen in the blood. It is less certain in its action than sulphonal, but has the one advantage over it of being moderately analgesic.

Paraldehyde, notwithstanding its bulky and unpalatable form, is justly growing in popularity. It is said to diminish the force and frequency of the heart's action, and occasions a brain anaemia, as occurs in natural sleep, but is still considered a valuable and safe medicine. In experiments to determine its effects, animals fed on chloral perished in about half the time of those fed on paraldehyde.

Of the third or vegetable class, I will only claim your attention for a moment to consider very briefly the several derivatives of *hyoscyamus*. They embrace hyoscyamine and its sulphate, and hyoscine with the hydrobromate and hydrochlorate of the same. For a thorough and interesting article on these and other hypnotics, I beg leave to refer you to a paper read by Dr. Henry W. Wetherill of the Pennsylvania Hospital for the Insane, at the last meeting of Superintendents of Asylums and published in the *American Journal of Insanity* for July 1889. The great advantages possessed by these products, are the smallness of the dose, ranging according to the preparation from $\frac{1}{2}$ to $\frac{1}{10}$ of a grain, their solubility and hence their fitness for hypodermic medication, though they are equally efficacious when given by the mouth, and the rapidity of this action.

The experiments of Dr. Wetherill, in the paper above referred to, showed conclusively that the hyoscine is by far the most reliable and efficacious. The disadvantages are mostly due to the uncertainty of the preparations in the market, as I am satisfied from experience, that many of them are entirely inert. I have found, for instance, that the hypodermic tablets gotten from a well known drug house in this city, gave perfect satisfaction, while the same article in bulk was useless and void of effect. Hyoscine is contraindicated in advanced cardiac lesions, in grave cardiac weakness and in

states of profound weakness. In mental disorders its range of general applicability seems to be almost universal, but with occasional failure, for which it is difficult to account. Individual idiosyncrasy is a term used as a shield to our ignorance of its effect on certain constitutions, or under certain circumstances.

IV. DISEASES OF THE PUERPERAL PERIOD. SEPTICÆMIA.*

BY WILLIAM S. GARDNER, M. D.,

Lecturer on Obstetrics in the College of Physicians and Surgeons, Baltimore.

(Continued from page 32.)

It is well to bear in mind the facts brought to light by Lusk, that in New York City, from 1867 to 1875, excluding hospital cases, one-thirtieth of all the deaths, and one-twenty-fourth of all the cases of metria are reported by *four* practitioners. Ten practitioners out of twelve hundred signed the death certificates of one-fifteenth of all the women dying from puerperal causes, and one-tenth of the cases of metria.

You can readily understand what an untoward event a death from this disease is, especially in the practice of a beginner. And it has been shown how often the attending physician is responsible for the disaster. This alone is enough to make every conscientious physician realize that when he is attending a case of labor, it cannot be considered a duty that can be lightly undertaken or carelessly executed.

Pathological Anatomy. In puerperal septicæmia there are various conditions found post-mortem. If the patient die within the first twenty-four hours, as they do in some epidemics, there are no gross lesions. But when the tissues of these cases are examined by the microscope, there are found cloudy swelling and granular infiltration of the cells, showing a beginning inflammation,

In patients living over twenty-four hours, there is almost invariably a marked inflammation of some of the serous membranes. The peritoneum is the one most frequently affected; and for this reason Gooch calls this disease "peritoneal fever." There is an exudation of plastic lymph, usually not great in quantity, and a considerable amount of serous fluid is poured out. The intestines are distended with gas, and are stuck together. Or, more rarely, the pleuræ or pericardium are involved and show the exudations of lymph and serum. Microscopically the fluid exudations are shown to contain large quantities of the chain-like micrococci. As has been stated, these micrococci are also found in the substance of the muscles, heart, kidneys and liver.

Prognosis.—The prognosis in septicæmia is always grave; it may terminate fatally within twenty-four hours. Twenty-eight cases in seventy-seven tabulated by Dr. Gordon were fatal; of these, six died before the fifth day, fifteen on the fifth day, three on the seventh, three on the eleventh, and one on the twenty-third day. From this it is seen that over thirty-six per cent. of the patients attacked died; and three-fourths of the deaths occurred on or before the fifth day. Dr. William Hunter was in the habit of informing his pupils that of thirty-two patients attacked by the disease in two months, only one recovered; and that treat them in what manner you would, at least three out of four will die. Some have even gone further than Hunter, and said that no genuine case ever recovers. This statement is undoubtedly too sweeping, for almost every one who has seen these cases at all has seen certain ones, in which the diagnosis was correct beyond question, recover. While the death-rate in the different epidemics has always been high, it has varied considerably, just as the death-rate in the different epidemics of small-pox varies.

Treatment:—There is no specific treatment for septicæmia. Indeed the various plans of treatment differ widely. The value of each form has been praised

highly by whoever happened to think he invented it; but the verdict of practitioners as a whole has not been given in favor of any definite line. And to-day the various results differ as widely as they did when Gooch wrote over fifty years ago: —“Richter could almost always cure it. Dr. William Hunter and Dr. Clarke could scarcely ever cure it. In Dr. Lowder's time it was observed that every woman who was bled died. In Dr. Armstrong's time it was observed that every woman who was *not* bled died.”

In Gooch's earlier practice he bled freely and often. In his later practice he almost entirely discarded bleeding and applied moist heat to the abdomen and gave, first a cathartic, usually calomel and jalap, and followed the cathartic by tincture of opium.

But it is hardly worth the while to review many of these older authors. The treatments that they used seemed to produce wonders in the hands of the individual who inaugurated them, and as a rule they failed signally when used by the general practitioner.

Alonzo Clark and many of his followers have used opium in large doses. In some cases treated at Bellevue Hospital a number of years ago, his instructions to his assistants were—“narcotize them within an inch of their lives.” The amount of opium given was gauged by the effect on the respiration. That amount was given which would keep the number of respirations down to about twelve to the minute. This plan has been very extensively used in this country, and probably with better success than any other treatment.

Fordyce Barker recommends highly the use of veratrum viride. But he says himself that:—“it should not be given in those cases in which rapid prostration is manifested by a feeble thread-like pulse, profuse sweats, and cold extremities.” If these exceptions are carefully followed I think there will be little veratrum used.

Quinine, Warburg's tincture, salicy-

late of soda, resorcin, antipyrine, antifebrine, phenacetine, cold baths, and cold packs have all been used to reduce temperature, and all with about equally negative results as to permanent benefit.

One of the more recent methods of treating peritonitis and including the peritonitis of puerperal septicæmia, is by the use of saline cathartics, especially magnesium sulphate; all other remedies being excluded.

Intra-uterine irrigation is also used but I cannot conceive of any possible good being done in this way. The pathogenic micro-organisms and their products are both in the system beyond the reach of any possible local treatment.

The treatment that seems to promise the best results in all hands is not exactly like any of the above, but more nearly resembles Gooch's later ideas. It consists of a full dose of magnesium sulphate given at once, and repeated every twenty-four or forty-eight hours; applications of moist heat over the abdomen; sufficient opium to allay pain, sufficient antipyrine or antifebrine to keep the temperature below 102.5° F. A large number of cases will not require any antipyretic; when one is used, it is best to leave it with the nurse with instructions to repeat the dose when indicated by the thermometer.

I do not think quinine of any value in these cases and have ceased to give it.

Mathews Duncan recommends for the flatulence, in extreme cases, the trocar canula, for the mild cases, charcoal.

Should the peritonitis go on to suppuration, the proper procedure is to make an abdominal section, wash out the peritoneal sac and drain it.

The careful administration of digestible foods is of great importance. Milk, eggs beaten up with milk, meat-jellies, and meat-juices should be relied upon. Beef tea is practically valueless. Some of these foods in as large quantities as the stomach will digest them should be given every two hours. In the attention to this matter of alimentation, a good nurse is of inestimable value, because I believe

this to be the most important point in the treatment of septicæmia. Some of the mineral acids preferably hydrochloric, well diluted, given every three or four hours will be of great assistance in keeping the stomach in good condition and promoting digestion.

Alcohol in some form is recommended by all authorities. Whiskey or brandy can be given most conveniently, and they are usually used; though should the patient have a preference for some special alcoholic drink, her taste should be satisfied.

From two teaspoonfuls to an ounce of whiskey or its equivalent may be given every two hours. Under its influence the pulse is said to become slower and fuller, and the respiration more regular. The amount to be given is regulated by the effect on the pulse.

INFLAMMATION OF THE VERMI- FORM APPENDIX ; ITS RESULTS, DIAGNOSIS AND TREATMENT.*

TOGETHER WITH THE REPORTS OF SEVEN
CASES OF EXCISION OF THE VERMIFORM
APPENDIX FOR PERFORATIVE
APPENDICITIS, WITH EXHI-
BITION OF FIVE OF THE
PATIENTS.

BY THOMAS G. MORTON, M. D.,
OF PHILADELPHIA.

(Continued from page 13.)

Irrigation with recently boiled or distilled water at a temperature of 105° to 110° , gives a clear view of the surroundings of the cæcum and its appendix; at this time it may be necessary to enlarge the wound in order to obtain sufficient space to conduct the necessary manipulations; this will be found especially

indicated when the appendix is more or less firmly glued to the intestine.

The appendix is practically always found to be the seat of trouble; in any case it should be excised; unquestionably so if swollen, inflamed, perforated, containing masses of feces, or harboring foreign bodies.

The removal of the appendix after gently freeing it from any adhesions which it may have formed can best be accomplished by ligaturing it close to its cæcal attachment with a silk ligature, and excising it just outside the point of ligation. If the general peritoneal cavity has not been involved by the abscess, nor during the necessary manipulations of excising the appendix, the abscess cavity should simply be washed out with a mercuric chloride solution (1 to 1000), and a good-sized rubber drainage-tube carried to the bottom of the cavity, and brought out near the most dependent part of the wound. In all of the cases which have come under my care the peritoneal cavity has been invaded by pus, either before or during the operation, so that the entire abdominal cavity had to be thoroughly cleansed and drained. Irrigation of the abdominal cavity can best be accomplished by a fountain (or other form of), syringe, carrying sterilized water of a temperature of 105° to 110° . Every part of the abdominal cavity should be thoroughly and repeatedly drenched if pus has entered it.

Should far-advanced peritonitis be found, the intestines must be withdrawn, and all adhesions parted with the finger or knife during the process of cleansing and before they are returned to the peritoneal cavity.

In any abscess of the ileo-cæcal region we should always suspect appendix disease, and an effort should always be made to expose this organ. In no case should a simple evacuation of pus be considered sufficient, especially if the history of the case presented any account of probable former appendix trouble. A case of this character came under my care, in which

*Read before the College of Physicians of Philadelphia, Jan. 1, 1890.

at first, in 1885, I simply evacuated an abscess situated in the ileo cæcal region, and made no investigation of the appendix, as the abscess cavity seemed a closed one. Three years later I was obliged to make abdominal section and remove a diseased appendix, which undoubtedly had existed at the time of the first operation.

Cæcal perforations should be cleansed, curetted, and closed by Lembert suture. If this be difficult or impracticable from the position of the perforation or otherwise, no danger need be apprehended, for such fistules close naturally; one such complication occurred in a case in which I excised a sloughing appendix. At the time of operation the cæcum seemed somewhat distended and its color unnaturally dark: forty-eight hours afterward feces were observed in the wound, which was sufficiently open to see a gangrenous perforation; the fistule gradually contracted, but continued discharging a small amount of intestinal contents for some months, when it permanently closed of its own accord.

If the inflammation should be found in the cæcum itself, due to the presence of a foreign body or to impaction of the feces, they should be either excised or urged by prudent force along the bowel.

In their operative removal a simple incision, afterward united by Lembert sutures, would answer every purpose.

When the general peritoneal cavity has been involved by the abscess, or broken into during operation, it requires, after cleansing, to be drained, and for this purpose a large, glass, perforated tube, slightly curved (Keith's), is carried down between the coils of intestines to the most dependent part of the pelvic cavity and allowed to emerge at a convenient point near the lower part of the wound. It is safer in all cases also to insert a perforated rubber drain to the bottom of the abscess cavity. The wound is then brought together by interrupted silk sutures.

A piece of protective tissue perforated for the tube exit is then applied to the

wound. To the bottom of the glass tube is carried a cotton rope which absorbs the secretions, and over its outlet a wad of cotton is placed and enveloped in rubber tissue in the usual manner. Iodoform is now dusted over the wound surroundings and a large dressing of wet bichloride gauze and cotton is then applied and held in position by a four-tailed flannel binder.

Post-operative Treatment.—After the effects of the anæsthetic have passed over, a hypodermic injection of morphine may be required to relieve pain, or check vomiting or restlessness. The ordinary rules of abdominal surgery are to be observed. The cotton rope should frequently be changed, generally every three hours is sufficient for the first few days; before it is replaced the tube should be irrigated with boiled or distilled water, peroxide of hydrogen, or weak carbolic acid solution, especially when, as is often the case at first, the secretions are more or less offensive.

Milk should be given at short intervals, and in small doses, and stimulants are, as a rule, early required; if there has been much exhaustion champagne should be freely given.

It is important that the bowels should be promptly opened and kept so; and for this purpose small doses of calomel should be given, say $\frac{1}{2}$ or $\frac{1}{3}$ of a grain hourly or half-hourly, with an occasional $\frac{1}{4}$ grain dose of podophyllin; after this salines may be substituted. Quinine and the malt extracts are strongly indicated. Opium should not be used in any form internally; morphine in small doses hypodermically rarely may be required subsequent to the operation to relieve pain or restlessness, but should be regarded as a dangerous agent and used with great reluctance.

It will usually be found that the cellular tissues surrounding the abscess are hopelessly infected and necrotic, perhaps for a long distance; it will likewise be found impossible to adequately remove or cleanse them. Hence the wound will almost invariably run a foul septic

course, great sloughs will keep coming away for many days, and it will eventually, in from six to eight weeks, heal firmly from the bottom by granulation and cicatrization. I have advised, nevertheless, that the wound always be primarily sutured, for by so doing and subsequently cutting suture after suture as the wound becomes tense, we secure an anchorage of the cæcum in the bottom of the wound by lymph exudate which prevents prolapse or hernia subsequent to cutting the sutures, or after cicatrization.

As a rule, one or two sutures must be cut at the end of twenty hours, others subsequently as tension may demand. When these are cut the already anchored cæcum, and perhaps other intestines, come into view as the wound widely gapes, but they show no tendency to prolapse even when the patient strains or coughs, although the latter—indeed all active motions—are to be strenuously avoided.

The gaping wound should be packed with strips of gauze which are to be frequently changed and the parts cleansed with peroxide of hydrogen until the tubes are away and the granulations approach the surface, then adhesive straps are used to approximate the wound edges. A binder, or good abdominal belt, must be worn for six months or a year after complete closure of the wound.

Symptoms of peritonitis after operation should be met by free saline purgation (Epsom salts, hourly or half-hourly), or by reopening and washing out the abdomen.

The time for the removal of the glass pelvic drain will depend altogether upon the amount and character of the secretion; usually it can be dispensed with by the fifth or sixth day, but frequently is retained until the tenth or twelfth. It is commonly forced out by the action of the intestines at the proper time. When it is removed, it is well to introduce in its place a small rubber drain, which can be each day brought nearer the surface and then cut away piecemeal.

The dressings should be replaced as

often as they become soiled, and this is generally every six or eight hours for the first few days, afterward at longer intervals.

I have thus gone over, in a more or less brief manner, the symptoms which should guide us in making the diagnosis of appendicitis and pus formation in or about the pericecal region, and have presented in as strong a manner as possible, the necessity, in such event, for early operative interference.

The details of the operation and post-operative treatment have been given with some minuteness, and this seems proper, because such specific directions have not been published.

In conclusion, it may be said that, although abdominal surgery can show many brilliant achievements, yet scarcely in any other instance does an operation so completely afford its own justification, or, when properly timed, present such satisfactory results, as laparotomy when performed for perforative appendicitis.

ADDENDUM.

The preceding paper, it will be observed, has been confined strictly to a consideration of *acute* forms of appendicitis. It is proposed in this additional note to consider in brief the subject of surgical interference with chronic appendicitis and those conditions which give rise thereto.

I have long been an advocate for removal of the diseased appendix in the interval between acute attacks; indeed, so long ago as in my first writing upon this topic, I urged that recurring attacks of appendicitis, or perityphlitis, should be considered an absolute indication for removal of the appendix; preferably after entire subsidence of an acute paroxysm, when every condition is so much more conducive to prompt recovery, and primary healing of the wound. I would now again aver that recurring attacks, or persistent chronic appendicitis, whether due to protraction in milder degree of the acute seizure or even orig-

inating and continuing without intercurrent acute attacks, not only justify operation, but absolutely demand excision of the appendix to insure the future safety of patient. For it must now be acknowledged that recurring attacks of appendicitis, usually, sooner or later, eventuate in that most dangerous of acute affections, perforation of the organ and pericæcal abscess; which, likely as not, will take place when the person is situated where adequate medical relief cannot be had. How much better, then, to place him at once, and for all time, beyond the possibility of danger from this source, by a comparatively trivial operation, at a time and under conditions when prompt and permanent relief can almost invariably be secured?

A study of the pathology of appendix disease shows that many cases commence as ulcerations of the mucous membrane of the appendix, which, with or without the formation and presence of concretions, progress to perforation, and, in either case, originate symptoms of intermittent or continuous chronic—perhaps disabling—appendix inflammation; and, earlier or later, either in the primary or a subsequent attack, give rise to perforation, abscess, and, when improperly dealt with, to death.

I would then reiterate my belief that symptoms of continuing appendix disease, continuing after an acute attack, or due to primarily chronic disease, or simply indicative of ulceration of the lining mucous membrane of the appendix, invariably demand excision of the offending organ.

All of the various distressing and often disabling symptoms of the various appendicular disorders, including those arising from inflammatory adhesions of the organ to neighboring viscera, are relieved, as if by magic, by excision of the appendix. This has been amply proved by the brilliant cases of Treves, Senn, Hoegh of Minneapolis, Bernardy and Shober of Philadelphia.

Operation for Chronic Appendix Disease.—The premeditated operation permits the careful preparation of the pa-

tient before-hand by rest in bed, regulated diet and bowels, and thorough general and local disinfection.

Incision should be made directly over and carried down through the right linea semilunaris. It should be at least three inches in extent and should be enlarged as may be required for necessary manipulation. After the peritoneum has been exposed to the full length of incision, all bleeding points are carefully ligatured with fine catgut and the wound is sponged entirely free of blood or other fluid. Now the peritoneum is incised. If the appendix does not at once present in the wound it will be necessary to press the intestine upward with the finger. If, as may happen, the appendix is found to be partially or wholly attached to the cæcum or elsewhere, the adhesions must be separated by the finger, or, if strong, be divided between double ligatures. The appendix may be entirely free of mesentery or the latter may extend throughout its whole extent; if so, this, as it were, meso-appendix must be ligatured in portions and cut through between the ligatures and the appendix. The latter organ is then included in a ligature at its cæcal origin and cut off.

A number of methods have been adopted for dealing with the resulting stump of appendix. If it is to remain projecting from the cæcum, the cæcal peritoneum should be brought over it and there united by Lembert sutures.

Although I have had no experience in the removal of the appendix for chronic disease, yet, from experiments made upon the cadaver with a view of getting entirely rid of the stump and hence of all subsequent danger from it, I have found that it can very readily be inverted and completely invaginated into the cæcal cavity.

The proposed manipulation consists, after ligaturing and cutting away the appendix, in grasping the stump at its distal extremity with forceps and pushing it into the cæcum; the peritoneum is then approximated over the inverted stump by means of three or four Lembert sutures,

which retain it in the cæcum, and effectually prevent its subsequent prolapse.

This is easily accomplished, and absolutely removes all source of danger from any future irritation in the *cul-de-sac* or that part of the appendix between the point of ligation and the cæcum. After the parietal wound has been carefully sponged and all clots removed, it is brought together by two rows of interrupted sutures; a deep set for the closure of the peritoneum and a superficial series to unite the edges of the external or skin and muscle wound. Drainage is not necessary unless under very exceptional circumstances. The external wound is to be dressed after the usual method, as previously described.

The diet for the first few days should be confined to liquids, especially milk, often and in small quantities. The bowels (which are supposed to have been opened well upon the morning of the operation), need not be disturbed for two or three days, when they should be stimulated to gentle activity by mild mercurial or saline laxatives. The dressings need not be disturbed for a week or ten days, when the sutures—if of silk—should be removed. A suppurating binder or abdominal belt should be worn until the cicatrix is quite firm.

Society Reports.

MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND.

(Continued from page 67.)

*Ninety-second Annual Session, held at the Hall of the Faculty, Baltimore,
April 22, 23, 24 and
25, 1880.*

DR. AARON FRIEDENWALD, PRESIDENT,
IN THE CHAIR. DR. G. L. TANEYHILL,
ROBERT T. WILSON AND WILLIAM B.
CANFIELD, SECRETARIES.

FOURTH DAY, FRIDAY, APRIL 25TH.

SECTION ON PSYCHOLOGY AND MEDICAL JURISPRUDENCE,

JOHN S. CONRAD, M. D., CHAIRMAN.

Dr. Charles G. Hill read a paper on
RECENT PSYCHOLOGICAL PROGRESS.

(See page 82.)

SECTION ON OPHTHALMOLOGY, OTOTOLOGY AND LARYNGOSCOPY,

H. C. MCSHERRY, M. D., CHAIRMAN.

Dr. Julian J. Chisolm read a paper on
THE EXCLUSION OF LIGHT IS NOT
BENEFICIAL IN THE AFTER-TREAT-
MENT OF CATARACT PATIENTS.

Volunteer papers were then read by
Dr. Geo. H. Rohé on

THE STATISTICS OF ONE HUNDRED OBSTETRICAL CASES,

by Dr. A. K. Bond on

THE LUNG DISEASES OF THE PREVAILING INFLUENZA,

(See page 46.)

and by

Dr. W. R. Monroe on

THE USE OF NITROGEN IN THERAPEUTICS.

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A German contemporary speaks of Succi, the fasting man, as a "hunger virtuoso."

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BALTIMORE, MAY 31, 1890.

Editorial.

THE SECRETARY OF THE STATE
BOARD OF HEALTH AND THE
MEDICAL ACT OF 1890.

Elsewhere we give place to a communication from C. W. Chancellor, M. D., Secretary, etc., which explains itself. The writer of this communication, having lashed himself into a fury, and having exhausted his vocabulary of expletives and venomous adjectives, undertakes to define the position of the State Board of Health in regard to the Medical Act of 1890. The defense here presented, if such it can be called, is now before the profession of this State for intelligent consideration. As an answer to the statement made by this JOURNAL, to the effect that individual members of the

Board of Health had been charged with having influenced Governor Jackson in his action toward the Medical Act, it is utterly insincere. As an attempt to evade the points at issue by the use of abusive epithets and high-sounding phrases, it is quite worthy of study. Having denied that any member of the Board, directly or indirectly attempted or desired to exercise an influence for or against the Bill with the Governor, the admission is made that certain criticisms were passed by an *individual member of the Board upon his own individual responsibility* on some of the expressions and provisions of the original Bill. We have it upon good authority that these very criticisms which this individual member of the Board passed upon the Bill, and which this individual member now admits were made, were used by the enemies of the Bill to prevent its passage by the General Assembly, and were subsequently brought to bear upon the Governor's mind. As to the exact language and character of these criticisms, the writer of this communication has not informed us. We can hardly assume that the legal and literary defects of the bill, so epigrammatically detailed by this writer, were the special objects of his animadversion. Whatever defects the Bill may have presented in these respects, as an act of legislation it met the views and wishes of a large majority of the profession of this State, and finally, with slight modifications, was enacted by the General Assembly.

In another direction we may seek the real cause of this individual member's unfriendly relations towards the Bill. "The Board, individually and collectively, has been at all times in full sympathy with the objects of the measure,

and would have aided cheerfully in securing an independent commission, if its co-operation had been requested. As it is, the measure was believed to have been set on foot for the purpose of stabbing the Board in the back, because it had not performed the impossible work of "making brick without straw." This apparently unguarded statement explains the *status quo*.

The profession of Maryland is familiar with the history of the act of 1888, and the reasons why this act was not enforced. The Board of Health under this act found itself unable to make "brick without straw." No serious fault was found with the Board for not organizing. Its position was fully understood. We, however, do not hesitate to say that disappointment was felt in the fact that the Board did not attempt to enforce the law. The profession was willing and eager to co-operate with the Board in the matter. It would have been a most popular step on the part of the Board, and would have given it an influence with the profession of this State, both advantageous to its work and to its avowed purposes. The temporary loss sustained by the Board would, in our opinion, have been doubly repaid by the profession, if not by the next Legislature. This, however, was a question for the Board to decide, and it decided adversely to the Medical Act. The profession was left for another period of two years without a medical law.

At a meeting of physicians in Hagerstown in November 1889, a movement was started to secure a law from the General Assembly of 1890. We say it without fear of successful contradiction that this movement was not designed as a stab in the back of the State Board of Health

and any statement to that effect is unjust and is unwarranted by the facts. The assumption of such an idea may possibly explain the feelings of the State Board towards the Medical Act of 1890, and may account for the criticism passed by an individual member of the Board upon the Act, but it does not truthfully represent the feelings of those gentlemen, who were instrumental in urging the passage of the Act, towards the Board of Health. We are prepared to believe that the assumption of the idea that an attack was made or designed by the originators of the Act of 1890, originated in the conscious feelings of the Board of Health on account of its failure to enforce the Act of 1888. Having failed in this plain duty to the profession of this State, the Board, *i. e.*, its Secretary was ready to resent any interference on the part of the profession in an effort to secure a medical law. The Convention which prepared the Act of 1890 did not, under existing circumstances, feel called upon to ask the co-operation of the State Board of Health as such. It felt competent to deal with this matter without the aid of this influence. In ignoring the aid of the Board it made no attack upon the Board. The Convention had the assurance of several members of the Board of their individual interest in its action. It was not known that individual members of the Board were unfriendly to the Act until this fact was communicated to members of the Committee on Legislation by members of the General Assembly. Hence we are prepared to assert here that whilst the State Board of Health as a Board did not oppose the passage of the Medical Act of 1890, whilst some members of the Board were passively friendly to the Act, that

an individual member of this Board did, as he admits, in his individual capacity criticise this Act and that this criticism was construed by his political friends as a direct opposition and attack upon the Act. Whether this individual member did, in his individual capacity influence the Governor, we are not prepared to say. He was not called upon to do so as his political associates were equal to this emergency. Had he been so much interested in the Act of 1890 as his communication would make believe, he might readily have foreseen that his criticism and attitude towards the Act were in the nature of a two-edged sword which would not only inflict injury upon the Act, but upon himself. Acting upon the erroneous assumption that an attack had been made upon the State Board of Health, *i. e.*, upon the Secretary, by the friends of the Medical Bill, he, the Secretary, *i. e.*, the State Board of Health, rushes to the rescue of the Board, *i. e.*, the Secretary, and criticises the action of those gentlemen who represented a Convention of the medical profession as having infringed upon the prerogatives of the State Board of Health, *i. e.*, the Secretary, and in their attempt to secure a medical law were stabbing the Board of Health, *i. e.*, the Secretary in the back. This is the logic of this question.

We have reason to believe on good authority that the Medical Act of 1890 was killed out of generous consideration for the State Board of Health, *i. e.*, for its Secretary. This statement has been made by his Excellency, if we can place any reliance upon the word of a gentleman, a confidential adviser of the Governor, (not the Attorney General as has been assumed). This presentation of facts is the entire upshot of the matter,

denials and assertions to the contrary notwithstanding.

The utterly contemptible insinuation of an attempt upon the part of this JOURNAL to misrepresent and falsify the position of the State Board of Health we indignantly repudiate. When this august body, *i. e.*, its Secretary, becomes too saintly to be criticized, or called to task for his work and conduct towards the medical profession of this State, then we may feel called upon to keep silence in the solemn presence of so profound an oracle, but as the times go we shall not feel intimidated by such charges as have been preferred of "prostituting position for the purpose of bespattering professional peers." People in glass houses should be careful how they throw stones. The attack which this JOURNAL made upon individual members of the State Board of Health should have been met with less ranting and more candor. The feeble attempt to conceal the true inwardness of this matter with a coarse and empty howl is not what the profession of Maryland desires.

For many members of the State Board of Health we have sincere respect and regard. We are frank to say that we do not hold them responsible for the political work of their Secretary. We regret to have been drawn into collision with such gentlemen. If they endorse the language and actions of their Secretary, who assumes to write officially, we must regret that they have permitted this official to become their mouth-piece upon such an occasion, and thus to belittle their organization in the respect and confidence of the profession of Maryland, between whom and the Board there should be most cordial and friendly relations.

The insinuation that certain members of the medical profession dickered with a professional lobbyist to secure the passage of the Medical Bill, and in lieu of money promised, rewarded his political services with a costly diamond ring, is an unjust attack, in keeping with the general tenor of this communication. The charge has no foundation in fact.

THE SECRETARY OF THE STATE
BOARD OF HEALTH AND THE
MEDICAL ACT OF 1890.

Correspondence.

Baltimore, May 21st, 1890.

Editor Maryland Medical Journal:

DEAR SIR:—I have read the editorial diatribe in the JOURNAL of the 10th inst., wherein you not only assail the Executive of the State, in a variety of choice words and phrases which deserve to be copyrighted, but you go out of your way to lug in the State Board of Health, which seems to be your special *bête noir*.

It is unnecessary to cite more than one specimen of your hallucination, which reads as follows: “The Governor’s confidential adviser has stated that the influence which destroyed the Bill (Medical Practice Act, 1890), originated with certain members of the State Board of Health.” Having rashly made the charge, you generously exclaim, “Let the Board individually exonerate themselves, if they desire to do so” Of course your columns are open for this purpose.

The extreme untruthfulness as well as the extreme imbecility of the charge has caused me, as the official representative of the Board, to hesitate whether I should accept your invitation or not; and were it not for the duty I owe to those of my colleagues who have trusted me through good report and through ill report, I should certainly leave the matter without a word in reply.

Who is the Governor’s “confidential

adviser?” is a question about which there should be no mistake. The Attorney General, who is closer to His Excellency, in the matter of signing bills, than any other official, and presumably his “confidential adviser” has stated that nothing transpired in connection with Bill, so far as he knows, that could justify the charge. It is difficult, therefore, to comprehend what sinister interests have prompted this unseemly attack. If unworthy prejudices had not blinded your editorial eyes, you might easily have perceived that in my last quarterly report, which was published in full in the *American* of the 24th April, I stated that, “While the State Board of Health was mainly instrumental in securing the passage of the Act of 1888 (entitled “An Act to Promote the Public Health and Regulate the Practice of Medicine in the State of Maryland”), it had no desire to be burdened with the additional duties and responsibilities, and was not, therefore, inimical to any change in the existing law that would relieve them of these duties.”

The Board, individually and collectively, has been at all times in full sympathy with the objects of the measure, and would have aided cheerfully in securing an independent commission, *if its co-operation had been requested*. As it is, the measure was believed to have been set on foot for the purpose of stabbing the Board in the back, because it had not performed the impossible work of “making brick without straw.”

That some measure of reform in the system by which persons are allowed to practise medicine is demanded alike by the interests of science and the claims of humanity is an incontrovertible proposition; and no one can be more firmly fixed in the faith, or more anxious for improvement in this direction than the State Board of Health, as is evidenced by the fact that the members have several times publicly proclaimed their willingness to execute the act of 1888, *whenever the necessary funds are provided for the purpose*.

If the Board had entertained the hostile

feelings which the JOURNAL seems disposed to attribute to it, it could, undoubtedly, have gratified those feelings by a simple protest before either branch of the Legislature, but it is well known that no such protest was made; and I am positive that no member of the Board, directly or indirectly, attempted or desired to exercise an influence, for or against the Bill, with the Governor. We had nothing whatever to do with His Excellency's course of action in the matter, and any assertion to the contrary is simply a misrepresentation of facts.

Beyond certain criticisms passed by an individual member of the Board, *upon his own individual responsibility*, on some of the expressions and provisions of the original bill, as published in the JOURNAL of the 11th of January, 1890, and which were subsequently changed or stricken out, not the slightest opposition was manifested against the measure. The right to criticise a public measure is as inherent as the right to criticise public men. I have no personal knowledge who the author of the so-called "Physician's Bill" is, but surely no sane man could read the original draft of that Bill, as presented in the Senate, and think that its author is above reproach, either as a lawyer or a scholar. The idea that any Bill presented in a Legislative body is sacred, and infallible in its provisions, involves at once the idea of a "Sir Oracle," who may be likened to an orient cloud floating in meridian splendor, and increasing in *breadth* and *expanse*, if not in lustre, till, after being fed with vanity as with incense, and soothed with flattery as with the music of the groves, it suddenly drops its magnificence and dissolves into thin air, without leaving a vestige of its early promises.

In your capacity as Autocrat of the profession, you require that "the Board, *as individuals*, repudiate" the charge of having influenced the Governor in his action towards the bill, or be forever *anathema maranatha*. For one, I bow before the Majesty of your power and the terror of your curse, and make answer

that the charge is not only false, but of mean and dastardly import. This unwarrantable attempt to injure the Board of Health has not occasioned me one moment's anxiety, or any other feeling except contempt for the persons who are so capable of prostituting their position for the purpose of bespattering their professional peers, who are endeavoring, under somewhat adverse circumstances, to do their duty, both as members of the medical profession and as members of the State Board of Health.

In conclusion, I will further say that when the JOURNAL, under whose genial auspices, we are led to believe, the true glory of the healing art can alone attain its full fruition, ceases to assail "certain members" of the State Board of Health, and turns its attention to "certain members" of the medical profession, who are "currently reported and believed" to have dickered with a professional lobbyist to secure the safe *accouchement* of their still-born bantling, and subsequently, in lieu of the money promised, rewarded his political services with a costly diamond ring, it may then lay claim to the respect and support of the Faculty of the State, and will then be entitled to the success which such a manly course would command. *Nous verrons.*

Respectfully,

C. W. CHANCELLOR, M. D.,

Secretary, &c.

CENSUS OF HALLUCINATIONS.

Editor Maryland Medical Journal:

DEAR SIR:—May I ask for the publicity of your pages to aid me in procuring co-operation in a scientific investigation for which I am responsible? I refer to the *Census of Hallucinations*, which was begun several years ago by the "Society for Psychical Research," and of which the International Congress of Experimental Psychology at Paris, last summer, assumed the future responsibility, naming a committee in each country to carry on the work.

The object of the inquiry is two-fold: 1st, to get a mass of facts about hallucinations which may serve as a basis for a scientific study of these phenomena; and 2nd, to ascertain approximately the proportion of persons who have had such experiences. Until the average frequency of hallucinations in the community is known, it can never be decided whether the so-called "veridical" hallucinations (visions or other "warnings" of the death, etc., of people at a distance), which are so frequently reported, are accidental coincidences, or something more.

Some 8,000 or more persons in England, France and the United States have already returned answers to the question which heads the census sheets, and which runs as follows:

"Have you ever, when completely awake, had a vivid impression of seeing or being touched by a living being or inanimate object, or of hearing a voice; which impression, so far as you could discover, was not due to any external physical cause?"

The "Congress" hopes that at its next meeting, in England in 1892, as many as 50,000 answers may have been collected. It is obvious that for the purely statistical inquiry, the answer "No" is as important as the answer "Yes."

I have been appointed to superintend the census in America, and I most earnestly bespeak the co-operation of any among your readers who may be actively interested in the subject. It is clear that very many volunteer canvassers will be needed to secure success. Each census blank contains instructions to the collector, and places for twenty-five names; and special blanks for the "Yes" cases are furnished in addition. I shall be most happy to supply these blanks to any one who will be good enough to make application for them to

Yours truly,

W.M. JAMES,
Harvard University,
Cambridge, Mass.

Reviews, Books and Pamphlets.

Chronic Urethritis and other Affections of the Genito-Urinary Organs. Three Lectures delivered at the Royal College of Surgeons, in June, 1889. By MATTHEW BERKELEY HILL, M. B. Lond., F. R. C. S., sometime Hunterian Professor of Pathology and Surgery at the Royal College of Surgeons of England, etc. With Colored Plates from Drawings by Frank Collins, M. R. C. S., L. R. C. P. London: H. K. Lewis, 1890. Pp. viii-47.

This monograph is the outcome of the lectures which have been reprinted from the *Illustrated Medical News*. The author's object is to describe the forms of chronic urethritis as studied with the endoscope and seen by reflected light, and the treatment of the troublesome discharge termed gleet, mainly by topical methods. Some description is also given of forms of prostatitis and of some affections at the base of the bladder, with the author's experience in their treatment. The colored plates seem to be very true to nature, but a long continued and intelligent use of the endoscope is necessary for a satisfactory diagnosis. The treatment is, in general, very satisfactory.

How to Examine for Life Insurance. By JOHN M. KEATING, M. D., President of the Association of Life Insurance Medical Directors, etc. Philadelphia: P. Blakiston, Son & Co., 1890. Pp. vi-9 to 211.

This is a very convenient little book, containing, in outline, directions for examination, in Part I, and instructions from various insurance companies, in Part II. The first part is very satisfactory, even if in places too concise. It is doubtful if many companies require an examination of the sputum for tubercle bacilli. The book is very valuable for one not up in modern methods of physical diagnosis.

Essentials of Gynaecology. Arranged in the Form of Questions and Answers prepared especially for Students of Medicine. By EDWIN B. CRAGIN, M. M., Attending Gynaecologist to the Roosevelt Hospital, Out-Patient Department, etc. With Fifty-eight Illustrations. Philadelphia: W. B. Saunders, 1890. Pp. viii-17 to 192. Saunders's Question Compends, No. 10.

Essentials of Diseases of the Skin, including the Syphilitic Dermata. Arranged in the Form of Questions and Answers, prepared especially for Students of Medicine. By HENRY W. STELWAGON, M. D., Ph. D., Attending Physician to the Philadelphia Dispensary for Skin Diseases, etc. With Seventy-four Illustrations. Philadelphia: W. B. Saunders, 1890. Pp. viii-17 to 270. Saunders's Question Compends, No. 11.

Essentials of Forensic Medicine, Toxicology and Hygiene. By C. E. ARMAND SEMPLE, etc., etc. With 130 Illustrations. Philadelphia: W. B. Saunders, 1890.

These three volumes are all condensed from larger works on similar subjects. They are in the form of questions and answers. The third one, by C. E. A. Semple, is very full and well illustrated. The others show no marked superiority to the usual cram books.

Popular Science Monthly, for May and June, 1890. New York: D. Appleton & Co. \$5.00 a year, 50 cents a number.

Both numbers contain articles of interest to suit the varied tastes of readers. In the May number, the article on "The Strength of Spiders and Spider-Webs," by Henry C. Mc. Cork, D. D., and "Wallace on Darwinism," by the Lord Bishop of Carlisle, are especially readable. In the June number, "Atmospheric Dust," by Dr. William Marcket, F. R. S., and

"Education and Crime," by Rev. A. W. Gould, will attract attention.

Atlantic Monthly, for May and June, 1890. Boston: Houghton, Mifflin & Co. \$4.00 a year, 35 cents a number.

The great attraction to this magazine is, among other good things, the series of articles called "Over the Teacups," by Oliver Wendell Holmes.

Scribner's Magazine, for May and June, 1890. New York: Charles Scribner's Sons. \$3.00 a year, 25 cents a number.

The interest in these numbers is centred in the Stanley articles, which the publishers have procured for their firm alone. They carry one back to the days when tales of adventure were daily bread, and are extremely interesting.

The Cosmopolitan for May and June, 1890. New York. \$2.00 a year, 25 cents a number.

This still continues to be the cheapest monthly magazine published, and is every month filled with a varied list of entertaining and instructive articles, all most lavishly illustrated.

Magazine of Art for May and June, 1890. New York: Cassell & Co. \$3.50 a year, 35 cents a number.

These numbers contain "The Literary Remnants of Albert Dürer," with some very characteristic sketches of that author, and also "Portraits of Robert Browning."

Apparatus for the Preparation of Bone Specimens, and for Arterial and other Injections. By OTIS K. NEWELL, M. D., etc., Boston. Reprinted from the *Boston Medical and Surgical Journal*.

Infusion of Salt Solution and Transfusion of Blood in Acute Anæmia; Their Relative Value. By Prof. J. MIKULICZ, of Krakau. Translated by Otis K.

Newell, M. D., Surgeon to Out-Patients, Massachusetts, General Hospital, Boston. S. J. Parkhill & Co., 1890. Pp. 16.

Miscellany.

PHTHISIS TREATED WITH CALOMEL.

Dr. Dochmann, in the *Deutsche Med. Wochenschrift*, Feb. 13, 1890, recommends calomel in the following formula, in the treatment of incipient phthisis:

Rv	Hydrag. chlorid. mitis	gr. x
	Pepsini	gr. lvi
	Tinct. opii	gtt xxx
	Ext. phellandrii	q. s.
Fiant	pillulæ nos. lx.	

The above formula will be found especially useful. The gastric complications are marked. In hemoptysis the opium may be replaced by ergot; and, if the cough is severe, extract of hyoscyamus may be substituted.

—*Medical and Surgical Reporter.*

INSOLUBILITY OF COMPRESSED TABLETS.

The case of a boy, æt. 8 years, is reported, in which compressed tablets of antipyrin containing 0.5 grm. each were administered for fever; the tablets passed through the intestinal canal unaltered. In a similar manner compressed tablets of phenacetin containing the same amount were given to a boy of 10 years for neuralgia; these two were discharged undissolved.—*Corres. für Schw. Aerzte — Journal of A. M. A.*

INHALATION IN PULMONARY PHTHISIS.

Professor Petresco, of Bucharest (*Med. News*, March 8, 1890), uses the following:

R	Eucalyptol,	
	Oil of turpentine,	
	Creasote,	aa 3 3
	Iodoform,	grs. 7
	Ether,	M 75—M

To be used in an inhaler.—*Weekly Medical Record.*

SIR ANDREW CLARK'S PILL FOR CHRONIC CONSTIPATION.

An anti-constipation pill, a little different from some others offered for the same purposes, bears the name of the eminent president of the Royal College. It contains one-half a grain each of aloin, extract of nux vomica, sulphate of iron, powdered ipecac and myrrh. This pill should be taken half an hour before the last meal of the day.—*Jour. Amer. Med Assoc.*

TO ACIDIFY THE URINE.

It is said that saccharin, in five grain doses thrice daily, will promptly acidify alkaline urine, to the great relief of cases of cystitis.—*Columbus Medical Journal.*

TREATMENT OF URTICARIA.

Attacks of urticaria occurring at night may be successfully aborted (says Dr. Ohman-Dumesnil, in *Med. Chips*, January, 1889), by the administration, at the time of the onset, of a pill containing one-sixtieth of a grain of atropine. Of course, the patient's general condition should receive subsequent care.—*Canada Med. Record.*

QUINSY.

Three or four grains of chloral hydrate, dissolved in an ounce of glycerine, is recommended as a gargle in quinsy. It is efficient by being locally antiseptic, astringent and sedative.—*Canada Med Record.*

A SIMPLE TREATMENT FOR CROUP.

According to the Paris correspondent of the *Medical Press and Circular* (April 16, 1890), a doctor from Toulouse asserts that he has had considerable success in the treatment of the above terrible affection by employing a tablespoonful of common sulphur in a glass of water, given by tablespoonfuls every two hours, the mixture being previously stirred. Sulphur is certainly not a new remedy for

croup or diphtheria; on the contrary, it is as "old as the hills," but the simple method mentioned may be tried by any one, and worth recording, perhaps.—*Therapeutic Gazette.*

ANILINE DYES AS ANTISEPTICS.

In an essay entitled "Aniline Dyes as Antiseptics," Professor Stilling, of Strasburg, claims to have discovered antiseptics strong enough to kill bacteria in a concentration not injurious to the human body, and at the same time diffusive enough to spread wherever on a wounded surface suppurative micro-organisms exist. In the case of a man of seventy, the whole of whose left leg between the ankle and knee was covered with ulcers, which would not heal, Prof. Stilling sterilized them all in a few days with the best result.—*Lancet.*

Medical Items.

The Lithia Springs in Green Spring Valley will shortly be controlled by an incorporated company.

There is a small chance that the Council will make the necessary appropriation for a much needed morgue.

The daily papers announce the death of Dr. B. S. Herndon, a prominent physician of Fredericksburg, Va.

Dr. John S. Dorsey who has opened an office at Solomon's, Calvert County, Md., is a graduate of 1890 and not of 1870 as stated last week.

Investigations into New York politics, have shown up some corrupt milk inspectors. The sick babies are the principal sufferers from this kind of dishonesty.

Some of the best members of the Dorpat University have been obliged to leave because the Russian government forbids lectures in German there,

Again we learn our bacteriology from the daily press. This time the announcement is that Dr. Chamberlain one of M. Pasteur's assistants has discovered that cinnamon is fatal to the typhoid bacillus.

The report of the New York Analyst of Drugs shows that the chances for getting drugs of good quality on prescription is 43.8 per cent.; fair, 17.4 ; inferior, 26 ; not as called for, 11.6; excessive strength, 1.2.

Much indignation has been expressed by physicians here and elsewhere at the circular sent by Dr. Billings for the Census Bureau. It is difficult to understand how Dr. Billings who has heretofore shown himself to be a man of good judgment, could affix his signature to such an absurd document.

Through the efforts of one man, Dr. Eugene F. Cordell, of this city, the cause of higher medical education has received a National support, and with few exceptions all the important medical colleges of the United States have pledged themselves to a three-year course and other reforms which will be noticed later.

In accordance with resolutions passed by the Brussels Academy of Medicine, the Belgian Government is about to forbid public séances of hypnotism. All who, "outside the lawful exercise of the art of healing," hypnotise girls aged less than 18 years or persons in a demented state, will be punished with fines and imprisonment.

The American Laryngological Association has just closed its 12th annual congress in Baltimore. The attendance was at no time large but the proceedings have been of great interest and much good work was done. The President Dr. John N. Mackenzie, gave the members of the Association and a few of the city profession a very handsome reception and sumptuous supper on Thursday night. The banquet was held on Friday night.

Why should we be disquieted because the University of Berlin sees fit not to recognize the degrees from American Medical Colleges? The U. S. Army, Navy and Marine Hospital, refuse recognition of the same degrees. Some States do likewise. Shall not foreign countries exercise similar rights? The fact is, Americans as well as Europeans know that an American medical degree is so uncertain in quality as to be worth but little.

At the Association of American Physicians, officers were elected as follows: *President*—Dr. William Pepper; *Vice-President*—Dr. H. M. Lyman; *Treasurer*—Dr. W. W. Johnson; *Secretary*—Dr. Henry Hun; *Recorder*—Dr. I. Minis Hays, *Members Elected*: Drs. Hobart A. Hare and J. P. Crozer Griffiths, of Philadelphia; Drs. T. S. Latimer and H. M. Hurd of Baltimore; Drs. S. A. Fisk and C. A. Denison, of Denver; Dr. C. S. Bond, of Richmond, Ind., Dr. R. L. MacDonnell, of Montreal, Canada. *For Honorary Membership*: Dr. Fordyce Barker, of New York.

The ladies of Austria are making a determined effort to carry the medical citadel by storm. On May 1st another petition was presented to the Austrian House of Deputies by Dr. Jaques on behalf of the Vienna Ladies' Association praying for the admission of women to the classes of the medical and philosophical faculties in the various Austrian universities. The petition bears the signatures of 3,619 ladies, including the members of the Association for the Extension of Female Education, the Association of Viennese housewives, governesses, school teachers, etc.

Dr. Paul Gibier, of the New York Pasteur Institute, submits the following statement for the month of April: During that month seven persons were treated at the institute. In three of these cases hydrophobia was shown to have existed in the dogs by the inoculation of other animals with the nervous substance of

the dogs that had bitten the patients. In the four other cases rabies was very probable, but the dogs had disappeared or their carcasses had been thrown away, instead of being sent to the institute. These patients are at present, all enjoying good health, as are also the thirteen patients inoculated during the month of March.

By direction of the Secretary of War, a board of medical officers to consist of Lieutenant Colonel Anthony Heger, Surgeon, Major John Brooks, Surgeon, Major Robert H. White, Surgeon, will assemble at the U. S. Military Academy, West Point, New York, on June 7, 1890, to examine into the physical qualifications of the candidates for admission to the academy and, in connection with the superintendent of the academy and commandant of cadets, the members of the graduating class. Reports of the proceedings of the board will be forwarded, through the superintendent of the academy, to the Adjutant General of the Army. Special reports will be made in the cases of any graduates deemed to be physically unfit for the military service, and also in the cases of candidates who may be admitted on probation or rejected.

At the Nashville Meeting of the American Medical Association the following officers for the ensuing year were elected: *President*: Dr. W. T. Briggs, of Tennessee; *First Vice-President*, Dr. C. A. Lindley, of Connecticut; *Second Vice-President*, Dr. R. C. Moore, of Nebraska; *Third Vice-President*, Dr. H. C. Wyman, of Michigan; *Fourth Vice-President*, Dr. L. P. Gibson, of Arkansas; *Treasurer*, Dr. R. J. Dunglison, of Pennsylvania; *Secretary*, Dr. W. B. Atkinson, of Pennsylvania; *Librarian*, Dr. C. L. Richardson, of District of Columbia; *Address on Medicine*, Dr. E. L. Sherman, of Michigan; *Address on Surgery*, Dr. J. M. Mathews, of Kentucky; *Address on State Medicine*, Dr. W. L. Schenck, of Kansas. The place of the next meeting is Washington, and the time, the first Tuesday in May.

MARYLAND MEDICAL JOURNAL,

VOL. XXIII. No. 6.

BALTIMORE, JUNE 7, 1890.

NO. 480

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Original Articles.

THE REMOVAL OF SUB-MUCOUS AND INTRA-UTERINE FIBROID TUMORS BY ENUCLEATION AND TRACTION, WITH REPORT OF 10 CASES.*

BY B. BERNARD BROWNE, M. D.,
OF BALTIMORE.

[Being Chairman's Report for the Section on
Obstetrics and Gynaecology.]

Various methods have been resorted to for the removal of these tumors. Separation of the pedicle by means of the ecraseur is the procedure recommended by most authorities. Thomas, Barnes, Skene and Tait recommend the ecraseur, while Emmett advises enucleation, and was the first to draw attention to the aid given by the expulsive efforts of the uterus in the removal of these tumors.

It would scarcely be necessary to state that there is no indication for the use of electricity in intra-uterine and intravaginal fibroids, if Apostoli had not carried its use so far as to apply it even in such cases.

The objection to the ecraseur is, first, the difficulty, or almost impossibility of applying the wire high enough up so that no portion of the tumor or pedicle be left behind in the uterus, there to undergo decomposition and develop septicæmia; and secondly, the danger of drawing in a portion of the uterine wall, and cutting it off, along with the tumor. This accident would be almost certain to occur if partial inversion existed at the time of applying the wire loop.

That these objections to the use of the ecraseur are valid and not imaginary, it is only necessary to refer to the literature of the subject.

By enucleation and traction both of these dangers are avoided, and if partial or complete inversion should occur (as in

*Read before the Medical and Chirurgical Faculty of Maryland, at its 92nd Annual Session, April 24th, 1890.

one of the cases which I shall report), no danger need be apprehended, as this complication is easily managed by the method which I will suggest.

The following cases are related as bearing upon this method of operation.

CASE 1.—Francis W., colored, aged 30, had had a very offensive discharge and profuse menorrhagia for six months before I saw her. The diagnosis of epithelioma had been made.

Upon examination, I found a large tumor filling up the vagina. The sound passed around the tumor up to the fundus where the pedicle was attached. The condition was found to be a sloughing fibroid. Disinfecting washes were used and the patient put under an anæsthetic. By continued traction, the tumor was gradually pulled down outside of the vulva; at the same time, the uterus was partly inverted. The pedicle was now enucleated and the uterus re-inverted. The tumor weighed 18 ounces. The patient made a good recovery.

CASE 2.—Miss S., aged 28, white, had been suffering with menorrhagia for several years. Upon examination, the cervix was found to be somewhat patulous; the introduction of the sound into the cavity of the uterus excited profuse bleeding. Under an anæsthetic, the cervix was thoroughly dilated, and the finger introduced into the cavity of the uterus, which was found to contain a pedunculated fibroid about the size of a small orange. By pressure over the uterus and traction upon the tumor, it was gradually drawn through the cervix, and the pedicle was then enucleated by the serrated curette.

CASE 3.—Mrs. T., aged 30, married 11 years; no children. Was seen by me in consultation. For three months, she had had very profuse flow at each menstrual period, and had lost so much blood that she remained in a state of complete collapse for 24 hours after each flow.

The uterus was found enlarged, and measured 7 inches in depth. The cervix was elongated and not patulous. Tupelo tents were inserted for the purpose of

preliminary dilation; on the following day, they were removed, and complete dilatation accomplished with Sims' large dilator and Hanks' hard rubber dilators. Upon introducing the finger into the cavity of the uterus, a large sub-mucous fibroid was felt; the lower corner of the capsule had ruptured, and a point of the tumor was projecting through this into the cavity of the uterus. In order to liberate the tumor, the mucous covering was slit up with long scissors, and by traction and enucleation the tumor was first drawn into the uterine cavity and then into the vagina. It had no pedicle, but was attached all around by its capsule. Weight, 14 ounces. The hæmorrhage in this case had begun at the time of rupture of the capsule.

CASE 4.—Mrs. M., aged 35, had been bleeding for several months. A bloody tumor was projecting into the vagina, and upon examination, over the abdomen a hollow indentation was found in the fundus. The diagnosis of inversion of the uterus had been made. Upon examining through the rectum, a much larger mass was found than would have been the case in inversion; besides, the mass was much harder than in inversion. The sound passed in on the right side and could be felt through the abdominal wall. The conditions here were very similar to those of inversion, but they did not correspond entirely. I concluded to pull the presenting tumor through the vulva so as to see the orifices of the Fallopian tubes, and if it proved to be inversion, and could not be returned by taxis, I intended to cut through the posterior surface of the fundus, dilate the constriction with a dilator passed up through the opening in the fundus, and then replace the uterus as in a case reported by me some time since (*N. Y. Med. Jour.*, Nov. 24th, 1883).

CASE 5.—Mrs. C., aged 33, white, married 7 years, has never been pregnant, has had severe dysmenorrhœa and metrorrhagia for several years. Her abdomen has become much enlarged in the past

year; the cervix was elongated and conical, with a narrow os uteri. The uterus was found to be much enlarged, and, upon dilating the cervix, a large fibroid tumor, with sessile attachment, was found in the cavity of the uterus. Complete dilatation of the cervix was obtained before any effort was made at removal, then several pairs of large vulsellæ forceps were introduced into the tumor. Traction was made first with one pair and then with another; at the same time, pressure was made over the abdomen by an assistant. After a considerable amount of traction, the tumor commenced to separate from its attachment. At this stage, Thomas' serrated scoop was passed up to the fundus, and by gentle pressure and leverage, the tumor was partially enucleated and drawn through the cervix. At this stage, two large corkscrews were screwed into the tumor, and complete removal of it thereby accomplished.

CASE 6.—Mrs. K., colored, aged 36, married, no children. Has had menorrhagia for several months, also a very offensive watery discharge during the intra-menstrual period. Upon examination, a large fibroid was found, partly projecting into the vagina. Expulsive uterine pains had been going on for two or three weeks before I saw her; these commenced after the administration of fluid extract of ergot, which had been given to check the haemorrhage. An anaesthetic having been administered, the uterus was thoroughly dilated, traction was made upon the tumor by several pairs of vulsellæ forceps, which were inserted into it at different points, pressure over the uterus was also made at the same time, and in about a half hour the tumor was enucleated, the uterus contracting firmly behind it.

This case resembled, very much, No. 1.

CASE 7. Miss F., aged 31, white, has had dysmenorrhœa and menorrhagia for 18 months. Abdomen considerably enlarged. Upon examination the uterus was found to be anteverted, the cervix was conical and elongated, the cavity of the uterus measured six inches. As it was impossible to obtain sufficient dilatation at

one sitting, the cervix was dilated moderately with a small dilator and plugged with three tupelo tents; these were allowed to remain in for 24 hours; upon their removal the cervix was softened and dilatable and upon inserting the index finger a tumor could be felt projecting into the uterine cavity and attached at the anterior portion of the fundus. By traction with vulsellæ, leverage with Thomas' serrated scoop and pressure over the abdomen, the tumor, the size of an orange was readily enucleated from its attachments and removed, the uterine surface being left almost as smooth where the tumor had been attached as at any other portion.

CASE 8.—Miss F., aged about 26, had been perfectly healthy until about one year before I saw her. During this year the first half, she had profuse menorrhagia and lost so much blood that she was obliged to remain in bed several days each month, then all flow ceased for about six months, and suddenly again, profuse haemorrhage began, and had continued for about a week in spite of all the usual remedies which were used to check it. At this time I saw her with her physician who had already detached a portion of a tumor projecting through the os. After dilating the cervix very thoroughly the tumor was seized and enucleated by traction and pressure over the uterus.

CASE 9.—M. D., colored, aged 35, married, one child 13 years old, has had menorrhagia for the past three years. About six months before I saw her, she felt a lump in her abdomen which was tender and painful. About four months after she first felt it, it suddenly disappeared and at the same time she had violent bearing-down pains, which continued at intervals until I saw her. Upon examination I found the vagina completely distended by a large tumor apparently as large as a foetal head. As usual in such cases where the tumor has passed partly into the vagina, the lower portion had commenced to undergo disintegration. With the patient under an anaesthetic several pairs of vulsellæ forceps were in-

serted into it so as to make traction from different directions at the same time. Finding it immovable, two large sized cork-screws were screwed into it; by the aid of these, with an assistant pressing down on the tumor from above, it was gradually drawn outside of the vulva and the pedicle enucleated with Thomas' serrated scoop. There was very little bleeding, and the woman left the hospital well, in two weeks after the operation.

CASE 10.—V. H., aged 34, colored, one child eight years old, has had menorrhagia for two years. Uterus enlarged and extended, cervix not dilated, uterus measured six inches. Upon dilatation a fibroid tumor as large as an orange was felt attached to the fundus. She was sent into hospital, and the tumor was removed by traction and enucleation.

Interference through the vagina with tumors that are entirely sub-mucous should be delayed as long as the condition of the patient will admit. Electricity and ergot frequently do good where menorrhagia is excessive. The uterine contractions excited by the agents also tend to rupture the capsule and force the tumor partly into the uterus cavity as in case 3. When the symptoms occasioned by sub-mucous fibroids necessitate surgical interference, it is generally safer to deal with them as in the interstitial variety, by removal of the uterine appendages.

In conclusion I offer for your consideration the following summary:

1st. By traction and enucleation we get the benefit of normal uterine expulsive power.

2nd. We do not incur the risk of amputating a portion of the uterus, or of cutting off a portion of the tumor and leaving it in the cavity.

3rd. We leave a clean intra-uterine surface.

4th. We have a perfect means of diagnosis between a projecting fibroid tumor and inversion of the uterus.

CURIOSITIES OF HOMOEOPATHIC PHARMACY.*

BY ROBERT KEYBURN, M. D.,

Professor of Physiology and Clinical Surgery, Medical Department of Howard University,
Washington, D. C.

Having recently obtained a copy of the circular and price-list issued by a dealer in high potencies, residing in New York City, I desire to impart to the members of the Medical Society, D. C., and the profession, some of the information therein contained. This document is a printed pamphlet of thirty-two pages, and is entitled "Catalogue of Morbific Products, Nosodes and other Remedies in High Potencies." These remedies are for sale at No. 13 W. 38th Street, New York City, by Samuel Swann, M. D.

Glancing over the catalogue, on page 16, we were struck by one article of the *Materia Medica* kept for sale, and called "luna, or, moonlight." How in the world is this obtained, and what are its properties? Astronomers have long disputed as to whether the rays of the moon possessed any heating power, but why need they any longer be in doubt, when they may be bought by the vial-full, and seen and tasted by ordinary mortals?

On page 20, we find three species of pediculi (or lice), on the list of remedies to be dispensed, namely, *pediculus pubis*, *pediculus capitis* and *pediculus corporis*. These minute animals we only expect to find on uncleanly persons, and the idea of swallowing them, or a preparation made from them, no matter how dilute, is rather startling to the uninitiated. The *pediculus corporis*, by the way, has a note in brackets after it, stating that this special lot came from Boston. The inquiry then arises in our minds, why is this? Are the Boston pediculi more voracious, or of larger size than those of other cities? What is the cause of their superiority? Unfortunately, the vendor of these delectable prepara-

*Read before the Medical Society of the District of Columbia, April 23rd, 1890.

tions does not condescend to inform us upon these points, so we are compelled to remain in ignorance.

On page 1, we find on the list the name "acarus scabies,"—translated, "lice insect." As the acarus mentioned is the one found in the disease known as the itch (in common parlance), and is not the pediculus, there seems to be a (h)itch in the Latin; but trifles like these need never daunt the swallower of preparations like these.

But, thank heaven, there is, on the first page, one familiar remedy, viz.: "adeps anserina" (goose grease). How well do we remember the vile odor of this substance when applied externally to the neck in our youthful days. To paraphrase Hamlet, "The offense was rank and smelt to heaven." Never did we imagine we should see it prepared in "high potencies" and given in granules.

On page 15, "lachryma filia" are defined as "tears from a young girl in great grief and suffering." In ancient Rome, small crystal or glass flasks have been found called "lachrymalia," which are said to have contained the tears of the mourners. Were these "lachryma filia" obtained from such sources, or are they the tears of some modern damsel, mourning, perhaps, like Miss Flora McFlimsey, because she had nothing to wear, or in utter desperation from the lack of a spring bonnet, or, it may be, crossed in hopeless love?

The explanation of "flavus irides," on page 11, is "yellow ray of the spectrum." Here's bottled sunshine with a vengeance! Photographers have long desired to fix the fleeting rays of the sun, and make their pictures glow with the colors of nature, and here we have them prepared and fit for internal medication. Would that we knew the secret of this preparation! One thing is certain: if we must swallow globules, it would be much pleasanter to think of swallowing bottled sunshine than a preparation of pediculus corporis, even though they were labeled as coming from the city of Boston.

On page 6 we find carbunculus (Swan) with the definition "pus from carbuncle on neck, very severe." We are not told whether the carbuncle was very severe upon the swan, or whether the pus obtained from it has been very severe upon the unlucky patient who takes it; perhaps both statements may be true.

"Fel gryllus Americana" (page 11) or "Brazilian cricket," is said to be beneficial for "suppression of urine with or without pain," and this important fact is also stated, that, "a boy who had chills and fever, swallowed a live cricket and never had a chill afterwards."

On the first page several dainties are provided for lovers of preparations of the high potencies. One is "adenia" or "glands from a person suffering from Hodgkin's disease;" a little further on is one made from the "ailanthus bug," an insect found on the odorous though unfragrant ailanthus tree. On the same page "albumenurea" is defined as "renal albumen" or in other words, the putrid and disgusting products of the decomposition of the human body as found in diseased urine.

On page 2, "anthracin" is said to be "pus from a carbuncle." On page 4, are two delightful compounds: one is from the "blatta Americana, or American cockroach," and the second is a more distinguished member of the same family namely, "blatta orientalis" or "East India cockroach." Farther down the same page is "bubo in syphilitica" or "pus from syphilitic buboes." On page 5, are a number of preparations of "calcarea" from different parts of the body, as "calcarea renalis" or "stone of the kidney," and "calcarea" from the lungs and bladder. On page 6, we have three preparations made from the different varieties of catarrh to choose from, namely: catarrh of the intestines, catarrh of the bladder, and catarrh of the nose. In this case you certainly "pays your money and takes your choice."

Page 7, gives us a little ray of hope, that we may not be called upon to swallow any more such vile compounds, for

there we find "cerulia irides" defined as "blue ray of the spectrum," but as if to dash our newly found hopes to the ground immediately, beneath is given a preparation made from the "chancr of syphilis."

Page 8 gives a remedy for constipation in newly born infants, viz, colostrum, found in their intestines previous to, and after birth. Page 9 gives preparations of two varieties of poisonous snakes viz, crotalus horridus (rattlesnakes) and crotalus cascavella. On the same page is "crusta lactea" commonly called "milk crust" and found on the heads of sickly or uncleanly babies. Farther down on the same page are preparations of diabetes mellitus, and also of the serum found in cases of dropsy.

Pages 10 and 11 give us preparations entitled electricitas or electricity, and galvanismus or galvanism. It has been said of our countryman Franklin, "that he brought down the lightning from Heaven for the service of man," but our homœopathic brethren can do more than that, they can make it edible and drinkable for ordinary mortals.

But time fails me, and I can only enumerate a few of the choice morsels obtainable in the high potencies. "Hippozinine," a preparation from the glanders, "lyssin" from hydrophobic patients, "osteo-necrosis" from necrosed or dead bone, pus from abscess of rectum, and caries of heel, pus from septic abscess.

Page 22 gives us rubrum irides, or red ray of the spectrum, and thus completing the list of rays of light used in the manufacture of these globules. On page 23 we find four varieties of cancer served up to us, viz.: of the breast, uterus, bowels and face.

Page 25 seems to show that Dr. Brown-Séquard's so-called elixir has been anticipated, for we there find two preparations, one "testiculo gallinæ," or testicles of the fowl, and one "testiculo muliebris sinistra," from the left ovary of a woman.

Many other preparations might be given, but I will conclude by giving an extract from the note after page 30. Dr. Swan says that the plan of sending

grafts has been adopted, viz.: "If a graft has been put into a vial filled with unmedicated pellets, and corked, the whole mas will be medicated in half an hour." Further down, on the same page, he says, "When a vial of medicine is nearly emptied, fill it with unmedicated pellets, and you will not have to purchase the remedy a second time."

Can the farce of humbug further go?

PNEUMONIA FOLLOWING THE "GRIPPE," *

BY C. D. BAKER, M. D.,
OF ROHRERSVILLE, MD.

On February 2nd at 4 P. M., I was called to see W. M., 18 years of age. I found him suffering with an acute pain in the left side, extending from the third to the fourth rib. Temperature $102\frac{1}{2}$ ° in the axilla, pulse 140, respiration 30. Dullness on percussion in the axillary and infra-axillary regions. Sputa mixed with blood.

This boy had been mail carrier up to the time of his illness. He walked six miles each day on his trips back and forth to the railroad in all kinds of weather thinly clad and poorly shod, often having wet feet from morning until night, eating one meal per day and living on cheese and crackers the rest of the time, using a quanity of tobacco each day in the shape of cigars of the cheapest kinds, pipe, cigarettes and chewing, weight less than one hundred. He was attacked with the grippe on the 25th of January, and remained in the house two or three days, but had no medicinal treatment. On the 29th he entered upon his work again and contrary to advice continued to carry the mail the rest of the week. On Thursday and Friday nights he walked a distance of four miles to meeting and did not return home until early morning.

*Read before the Washington County Medical Society at Hagerstown, Md., April 9th, 1890.

Hence the pneumonia, invited by the continued exposure insisted upon by the lying upon the cold ground and damp stone fences for three or four hours on Saturday as well as the soaking from the rain, did nothing unexpected in selecting the left lung as its dwelling place. I placed him on five grain doses of quinine sulphate every six hours, only one dose of which was taken, two-drop doses of tincture of aconite root every two hours until three doses were taken, I also gave a mild cathartic.

On Monday morning the temperature was $104\frac{3}{4}^{\circ}$, pulse 144, respiration 60, and he was vomiting yellowish substance having the appearance of the yolk of egg. He had not retained anything on his stomach for six hours. There was present at this time the prune juice expectoration. I ordered 15 grains of antifebrine every four hours, poultices to the affected lung, alternated with turpentine stapes. Milk diet with lemonade *ad libitum*.

On Tuesday morning the temperature was 103° , pulse 120, respiration 35; the stomach was quiet and he rested well until after 12 o'clock the preceeding night.

On Monday morning his mother said that his water was as black as tar. I did not pay much attention to the statement, but told her to save the next until I came again. On my visit on Tuesday morning she showed me a chamber half full of urine, black as tar, and thick as rich milk, with an extremely sickening odor. She stated that the chamber was perfectly clean before he used it, and that nothing had been put into it since.

During the night previous he drank over a pint of strong coffee. I am sorry I did not make an examination of his urine, but as the grippe had a strong hold upon myself just at this time, I did no more work than was absolutely necessary.

I continued the antifebrine in doses of ten to fifteen grains, and gave tablespoonful doses of liq. ammon. acetatis every two hours, and had the satisfaction of finding, the next morning, a

temperature of 101° , respiration 24, pulse 100, urine nearly clear. Sputa mucous, with bloody streaks, and bowels open. From this time, he continued to improve, until about the 14th day, when he sat up for the first time. I have no theory to offer as to the dark urine. In my meagre library there is nothing of the kind mentioned. I think this case somewhat unusual, from the violence of the attack subsiding under the use of the antifebrine treatment and the debilitated state of the patient, as well as following so closely upon the grippe.

I have now three cases; as they are so much alike, I will give them together. They were diagnosed acute pneumonitis, but as we among the mountains are not as careful diagnosticians as our city brethren, we would like their opinions fully upon these cases.

The symptoms were, chill, followed by intense pain in the axillary region of the left and right sides, extending toward median line of the chest. Temperature between 104° and 105° , pulse 140 to 150, respiration 35 to 40.

Two of these was seen during the chill stage, to which I gave 10 grains of sulphate of quinia, followed by 10 grains of antifebrine every 4 hours, and two drops of aconite every hour until 6 drops were taken.

The other case I saw just after the chill left him, and gave phenacetine, followed by the 3 doses of aconite and then by the antifebrine.

The bowels in all cases were open, urine scanty and high colored. Turpentine stapes were used in all three. In one, the pain was so severe that I had to give $\frac{1}{4}$ of a grain of morphia, hypodermically. In two cases, the sputum was rusty colored; in the third, blood, with small amount of mucus. There was dullness on percussion, and fine crepitant rales, on auscultation.

In all three cases, there was not the slightest rise of temperature after the first 24 hours; in one case, none after the first 8 hours. This was the case in which I gave the morphia. Pain and

expectoration continued from one week to ten days. All had the grippe two to four weeks previously, from which they made good and speedy recovery.

MEDICAL AND SURGICAL SOCIETY OF BALTIMORE.

STATED MEETING HELD FEB. 13TH, 1890.

The 706th regular meeting of the Society was called to order, Dr. H. T. Reynolds in the chair.

Dr. D. W. Cathell related several cases of

ERYTHEMA NODOSUM.

He said he had seen four cases last year, all occurring in adults, and all being dependent on overwork and nerve prostration. Three were in females and one a male. The man was a shoe dealer, who, in addition to his usual work as proprietor, undertook to take the place of his drummer, who was sick. To do this, he made three visits per week to Washington D. C., losing a great deal of rest, besides performing the additional labor. Two of the ladies were attacked after nursing their husbands through sickness. The other lady, in consequence of the effort and exposure in preparing a new house for occupancy, by a given time, had an attack of *la grippe*, followed by erythema nodosum.

This group of four cases gave more trouble than any other group of cases he had ever had. The pain in the nodes is a particularly troublesome symptom. The second crop of nodes are usually less painful than the first. The patient complains bitterly of this pain, especially if there be nodes on the feet. We cannot use anodynes always, yet we are required to give some relief. Tonics are necessary, but the nausea prevents the administration of some of our best bitter tonics.

He had not given as grave a prognosis in the first case as he should have, and in consequence he had two consultants.

In each case he foretold the lemon color which the nodes take on in defervescence and by so doing had engendered the confidence of the patient. After using various astringent lotions locally, he found the following to give great satisfaction in all the cases.

R,	Ol. camphorat.	ʒ ii ss
	Vini opii	ʒ ss
	Ol. sassafras.	ʒ ii
Misc.	Sig: locally.	

Dr. Thomas B. Evans said some time ago he had attended a child with croup, and a few days after having discharged the case, he was sent for and found several patches of erythema nodosum on the limbs of the child. About four weeks after, it had a second attack, and is now suffering a third. The frequent recurrence is the puzzling feature in this case.

He thought it might be due to the dye from goods made up into overcoats in the house, (the father being a tailor). but was not satisfied as to that.

Dr. A. V. Gosweiler then read an interesting paper on

CHARLATANISM,

depicting the charlatan and his methods.

Dr. Thomas B. Evans said a lady patient of his was operated upon for

CARCINOMA OF THE BREAST.

There was a recurrence. Eight months after the first operation, she was examined and a second operation deemed unavoidable and a grave prognosis was given.

The husband, insisting on doing anything that promised a hope, had a "cancer doctor" (who also revelled in the title of Rev.) from a neighboring county to see her. This gentleman (?) visited her several times, collecting \$25 at each visit. He said he would cure her in three months. He put on an isinglass plaster to remain ten days, after which he ordered poultices to be applied. The usual result was attained in this case; the

quack had a pocket-full of money and the undertaker had charge of the body.

Dr. D. W. Cathell said he had had a good illustration of the food adulteration referred to in Dr. Gosweiler's paper, while attending a colored man with typhoid fever who lived on a narrow street. From the patient's room, he could see across the street into the second story of a spice mill. He was informed that several heaps of queer looking material, were yellow corn meal, charcoal and old crackers, which were used in the adulteration of a brand of mustard put upon the market by this mill.

Dr. Wm. H. Norris said, some years ago a gentlemen in Baltimore county had been treated by some of the best physicians of this city for cancer of the stomach. He finally fell into the hands of a quack (who was also a preacher), who treated him with plasters and poultices. The patient died, uncured. The administrators refused to pay the bill of the quack. The case was referred to a committee, who failed to agree. He then sued the estate and recovered.

Dr. Wm. H. Norris read a paper on
MALARIA AND ITS PATHOLOGY.

Dr. Thos. B. Evans said "malaria" was an unfortunate term; it is an Italian word, meaning bad air; this, of course, does not convey any intelligent meaning as applied to this disease.

Dr Frank C. Bressler said, while the term "malaria" was defective in some respects, in practice you will find it a very convenient term. You may be called to see a patient who has no fever, but who complains of malaise, gaping and soreness. No diagnosis can be made. You give your patient quinine, grain v, for two days, and he is much better. What would you call it? It is a term we cannot exclude until we find a better.

As to the pathology of fever, we are in the infancy of our knowledge. All the later writers say that fever is dependent upon some disturbance of the nervous system.

Dr. Wm. S. Gardner said he knew of a student of medicine who presented himself for examination when in a very

excited state. The professor took his temperature and found it to be $103\frac{1}{2}$ ° F. He advised him to defer the examination until he became more composed. The student said he had come to be examined and wanted to have it done with. He stood his examination, and one hour thereafter his temperature was normal. The question of the elevation of the temperature is in an unsettled state. In typhoid, the ptomaine has been demonstrated; it has been isolated and when injected in animals it produces the same symptoms, as also in tetanus. If the elevation of temperature in these diseases is dependent on the ptomaine (?), why should we not have it in all the infectious diseases where micro-organisms are present?

J. WM. FUNCK, M. D., Sec'y,
1710 West Fayette Street.

TRICHLORACETIC ACID IN DISEASES OF THE NOSE AND THROAT.

Ehrmann, of Heidelberg (*Therapeutische Monatshefte* April, 1890), reports success with trichloroacetic acid as a cauterant in diseases of the nose and throat. The crystals were applied by means of a silver applicator. The treatment was employed in 140 cases, including hypertrophy of the turbinated bodies, circumscribed polypoid hypertrophy, hypertrophic tonsilitis, hypertrophied uvula, follicular pharyngitis, and hypertrophy of the lingual glands. In 87 of these cases the cauterization was made but once, in 30 cases twice, and in the remainder from three to five times.

The author believes that trichloroacetic acid is much preferable to chromic acid, in that the cauterant effect is more localized and forms a much thicker eschar.

As an astringent, Ehrmann has employed the acid in the following mixture:

R.—Iodine	2 grains.
Potassium iodide . .	3 "
Trichloroacetic acid .	4½ "
Glycerin. . . .	7½ drachms

But as yet he refrains from expressing an opinion upon the value of this application. The acid used was that manufactured by Merck.—*Med. News.*

MARYLAND MEDICAL JOURNAL

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BALTIMORE, JUNE 7, 1890.

Editorial.**ON COCAINISM.**

For the origination of this new drug habit, two recent discoveries of science were needed—the use of the hypodermic needle and the method of extracting cocaine from the coca leaf. The effects of the drug are generally obtained, by those who enjoy it, through hypodermic injection.

In the *Edinburgh Medical Journal*, March, 1890, page 806, the effects of the cocaine habit are briefly described by Dr. Clouston. His conclusions are that

1st, It is the acutest and most absolute destroyer of inhibition (self-control), and of the moral sense known to us.

2nd, The morbid craving is very intense.

3rd, The dose requires to be increased more rapidly than that of any similar drug.

4th, The delirium and the hallucinations of all the senses which follow single doses, become chronic where the habit is continued.

5th, The immediate effects of the injection are more transient than those of similar drugs, but this is not true of the craving which is excited.

6, The treatment consists in outside control of the patient, a very strict watch being necessary, as the patient may commit suicide during the first week of abstinence. The drug should be stopped at once, and nourishing food should be given with bromide of ammonium, brandy or wine, tea or coffee, and perhaps a hypnotic, as paraldehyde or sulphonal, for two or three nights. The trouble with hospital treatment is that the delusions vanish quickly, while the tendency to relapse continues long after the friends secure the patient's discharge.

Two examples of extreme cocaineism are given, one of which will bear quoting. A young professional man, cheerful, fairly industrious and steady, with a history on his mother's side, of paralysis and phthisis, took morphia hypodermically for 18 months for relief of pain, and then attempted to break off the habit by the aid of hypodermics of cocaine. The cure proved worse than the disease, for the exhilaration of the cocaine was very transient and the after-depression required repetition of the dose at briefer intervals than when morphia was taken. The moral deterioration of the cocaine habit was ten-fold worse than of the other. Want of system, neglect of social and other duties, and untruthfulness, followed one another, and at the end of three months delusions of suspicion and

hallucinations appeared. A peculiar delusion was caused by paræsthesia, the feeling as if germs were moving in the skin. When he put himself under control—from want of money to buy drugs—he was taking as much as 90 grains of cocaine and 20 grains of morphia each day. A few doses of morphia and cocaine were given at first, then these drugs were stopped. The patient when last seen seemed to have quite recovered.

HIGHER MEDICAL EDUCATION.

Not many months ago, it suggested itself to a medical man of this city that the cause of Higher Medical Education would be better championed if the colleges of this city would agree on uniform advances in teaching medicine. This meeting was not a success. A second meeting was called and then nothing much was accomplished.

Nothing daunted, the instigator of this reform kept attacking the schools until the affair attracted attention outside of the city, and Dr. E. F. Cordell, to whom alone credit is due for starting this reform, had the satisfaction of knowing at Nashville last month, that 55 schools out of about 100 regular active medical schools of this country, met by delegates and agreed on certain reforms. The result of this meeting was communicated to all the 100 schools, so that the remaining 45 which were not represented, may have an opportunity to subscribe to this reform.

The changes proposed and adopted are to be enforced in the session of 1892-93, and are as follows:—Preliminary examination in English, higher arithmetic, physics, and Latin, a three-year graded course and laboratory instruction in physiology, chemistry and pathology.

There was much discussion on the advisability of requiring Latin in the preliminary examination and the schools of the South and West with some exceptions, objected to Latin on the grounds that not only would it be suicidal to those schools, but the little Latin required would be of little use to the student. Still these schools hoped to able to require Latin in the next two years.

While Harvard and other schools which have long since fulfilled these requirements were represented at this meeting and gave their sanction, it was very noticeable that no New York school was represented. Comment is unnecessary.

When this meeting was first called in this city in January, one or two of the schools were not represented, but at a later meeting all five, with the Johns Hopkins Hospital, took part. At Nashville all of the Baltimore schools were represented except the Baltimore University School of Medicine, and that will probably fall in line before 1892.

As this reform seems to be a sincere move and will undoubtedly improve medical education in this country, it reflects great credit on the originator. The time may come when our schools will receive recognition all over the world.

Reviews, Books and Pamphlets.

May's Diseases of Women, being a Concise and Systematic Exposition of the Theory and Practice of Gynaecology. For the Use of Students and Practitioners. Second Edition, revised by Leonard S. Rau, M. D., Attending Gynæcologist to Harlem Hospital, Outdoor Department, New York, etc. With Thirty-one Illustrations on Wood. Philadelphia: Lea Brothers & Co., 1890. Pp. xii-25 to 373. Price \$1.75.

This is a manual well adapted for the student, but almost too concise to be of much use to the physician. The subject is clearly stated, but the condensed descriptions and list of possible causes of the various troubles described render the book in parts a little confusing. It is, however, up to date, and may be used to advantage by the student, who should also possess larger manuals. No author should let the expression "per vagina" (p. 27), appear in his book. Also, on page 41, it would be better to use the Latin "vestibulum" in describing the anatomy of the vulva, when all the other terms are in that language.

Electricity in the Diseases of Women, with Special Reference to the Application of Strong Currents. By G. BETTON MASSEY, M. D., Philadelphia, etc. Second Edition Revised and Enlarged. Being No. 5 in the "Physicians' and Students' Ready Reference Series." Philadelphia and London: F. A. Davis, 1890. Pp. 246. Price \$1.50 net.

This is a second edition of a very popular book already noticed in these columns (Vol. XX, p. 353). While enthusiasm in electricity in gynaecology has returned to its proper level, the subject has by no means been neglected. The work has been greatly improved and much new in treatment has been added, while the reader may have the satisfaction of knowing that the author has verified each statement made. The book deserves a careful study by the specialist.

A History of Spectacles. By L. WEBSTER FOX, M. D., Ophthalmic Surgeon to the Germantown Hospital, Philadelphia. Reprinted from the *Medical and Surgical Reporter*, May 3, 1890.

The Relation of Homœopathy to Gynaecology or Sectarianism in Medicine. By PROF. MARY A. BRINKMANN, M. D. Reprinted from the *Homœopathic Journal of Obstetrics, Gynaecology and Pathology*, March 1890.

Stricture of the Rectum, Intestinal Obstruction, Inguinal Colotomy. A Clinical Lecture delivered at the New York Post-Graduate Medical School Hospital. By CHARLES B. KELSEY, M. D., Professor of Diseases of the Rectum. Reprinted from the *Medical News*, April 26, 1890.

Large Doses of Iodide of Potassium. By AUGUSTUS A. ESHNER, M. D., Resident Physician at the Philadelphia Hospital. Reprinted from the *Medical and Surgical Reporter*, November 23, 1889.

The Blunt Curette in Uterine Haemorrhages By THOS. W. KAY, M. D., Scranton Pa. Reprinted from the *New York Medical Journal* for November 2, 1889.

Pulmonary Consumption in the Light of Modern Researches. By STEPHEN SMITH BURT, M. D., Professor of Clinical Medicine and Physical Diagnosis, New York Post-Graduate Medical School and Hospital, etc. Reprinted from *The New York Medical Record*, April 12, 1890.

Miscellany.

IS EDUCATION OPPOSED TO MOTHERHOOD?

In America, in "a report given of the family conditions of one hundred and thirty alumnae who have had children, the exceptional record of good health among these children, and their low death-rate, are strong evidences that the powers of motherhood have not suffered from college work." In addition, the writer's mite of testimony may be offered. In the schools which she has attended, the majority of earnest students were in uniformly good health; a minority were delicate before beginning study. The most frequent examples of ill health were found among those who made a pretense

of study and eagerly pursued social excitements. Subsequent effect upon the health may be judged when it is found that twelve years after graduation, one young woman, ranking at the head of her class, is the mother of six vigorous children; two others, earnest students, have each a family of five, and a number of others have four children. No correspondence has been held with married class-mates living at a distance. These mentioned are personally known to be mothers in the fullest sense, and constitute striking contradictions to the claim that education has an injurious effect upon woman. "But," it may be objected, "these are exceptionally healthy women." Undoubtedly, but if the training has any influence at all, it should make them fall slightly below the standard of the proceeding generation, whereas in several instances, they improved upon the record of their mothers, not only in general health, but in the condition and size of their families.—ALICE B. TWEEDY, in the *Popular Science Monthly* for April.

CONSTIPATION IN WOMEN.

Dr. Lutaud recommends the following in obstinate constipation occurring in women:

R. Citrate of iron and ammonium . . . 31 grains.
Fl. extract of cascara sagrada . . . 32 minimis
Saccharin . . . 8 grains.
Water . . . 2½ ounces.

M.—A half teaspoonful three times daily before meals.—*Medical News*.

TUBERCULAR PERITONITIS

From a study of this subject, based on personal experience, Dr. William Osler has formulated the following conclusions: 1. Tubercular peritonitis is often a latent affection, localized in the peritoneum, which may even run its course without inducing special symptoms. 2. As in other local tubercular processes,

there is in this a natural tendency to healing, which takes place more frequently than has hitherto been supposed.

3. Statistical evidence shows laparotomy to be in many cases a palliative, and in a certain number a curative, measure.

—*The Johns Hopkins Hospital Reports*, February, 1890.—*Medical Record*.

LINIMENT FOR NEURALGIA.

R.—Camphorated alcohol . 90 parts.

Ether 30 "

Tincture of opium . 6 "

Chloroform . . . 20 "

M.—Sig. Apply on flannel.

—*Journal de Médecine*.—*Times and Register*.

LEUCOPLAKIA OF THE TONGUE.

Dr. Rothmann, writing on leucoplakia, or white patches of the tongue, describes ten cases of this affection which have come under notice in Professor Bergmann's clinic in Berlin. The liability of these patches to become carcinomatous, which was first pointed out by Mr. Hulke, is so well recognized that Dr. Rothmann says the patches may take on malignant characters, even after they have existed for thirty years. As to treatment, it was found that the best plan was to destroy them entirely with Paquelin's cautery, though of late Peru balsam has been employed with success.—*Lancet*.

RÖTHELN OR MEASLES.

From an interesting paper by Dr. Chas. W. Townsend, of Boston, in the *Archives of Pediatrics*, April, 1890, we extract and subjoin the following conclusions in which the author says:

"(1) Epidemics of measles occur in which many of the cases exactly resemble cases described as rötheln.

"(2) That these cases are also found occasionally in severe epidemics of measles.

"(3) That glandular swellings and sore throat are sometimes found in cases of undoubted measles and are sometimes absent in cases called rötheln.

"(4) That the symptomatology of rötheln is not distinct from that of measles.

"(5) That it is therefore impossible to make a diagnosis of rötheln from a single case.

"(6) That the only ground on which the individuality of rötheln rests, is the fact that previous attacks of measles afford no protection from this disease.

"(7) That as second attacks of measles do occasionally occur, we cannot, from our present knowledge, make the diagnosis of rötheln, unless—as in the Charterhouse and Asylum epidemics—we meet with a series of cases in patients, many or most of whom have previously had measles.

"(8) That the impossibility of knowing how many second attacks may occur in a given epidemic of measles makes this proof of the separate existence of rötheln somewhat problematical, and gives rise to the question, Is it possible that in some epidemics and not in others a mild form of measles attacks equally those who have had measles before and those who have not, and affords afterwards no protection from measles?"—*Boston Medical and Surgical Journal.*

OPERATION FOR ARRESTING MYXEDEMA.

Mr. Victor Horsley sometime ago called attention to the hæmacytopoietic function of the thyroid gland. His opinion was primarily based upon operations conducted by Scheff, who found by operating on dogs that "thyroidectomy loses its danger and an essential amount of its effect if one previously introduces and fixes in the abdominal cavity other thyroid glands from an animal of the same species." In the case of the dog, the animal is doubtless saved from death from anaemia, by the gland-substitution in the abdomen. This leads Mr. Horsley to the opinion that transplantation of thyroid tissue might act beneficially with man in arresting the progress

of myxœdema, cachexia strumipriva, and other allied diseases. The thyroid of the anthropoid ape would probably be the best to transplant, but failing in this it is pointed out that the thyroid of the sheep much resembles that of man. The test of the value of such a procedure would be best indicated by the effect produced on the anaemia.—*Physician and Surgeon.—Cincinnati Lancet-Clinic.*

HOW THE COUNSELLOR'S FRIEND RAN THE GAUNTLET OF THE SPEC'ALISTS.

"My family doctor," he said, "was a very sensible man, educated at a school where they professed to teach all the specialties, but not confining himself to any one branch of *medical* practice. Surgical practice he did not profess to meddle with, and there were some classes of patients whom he was willing to leave to the female physician. But throughout the range of diseases not requiring exceptionally skilled manual interference, his education had authorized him to consider himself, and he did consider himself, qualified to undertake the treatment of all ordinary cases. It so happened that my young wife was one of those uneasy persons who are never long contented with their habitual comforts and blessings, but always trying to find something a little better,—something newer at any rate. I was getting to be near fifty years old, and it happened to me, as it not rarely does to people at about that time of life, that my hair began to fall out. I spoke of it to my doctor, who smiled, said it was a part of the process of reversed evolution, but might be retarded a little, and gave me a prescription. I did not find any great effect from it, and my wife would have me go to a noted dermatologist. The distinguished specialist examined my denuded scalp with great care. He looked at it through a strong magnifier. He examined the bulb of a fallen hair with a powerful microscope. He deliberated for a while, and then said: "This is a case of *alopecia*. It may perhaps be par-

tially remedied. I will give you a prescription." Which he did, and told me to call again in a fortnight. At the end of three months I had called six times, and each time got a new recipe, and detected no difference in the course of my "alopecia." After I had got through my treatment, I showed my recipes to my family physician; and we found that three of them were the same he had used, familiar, old-fashioned remedies, and the others were taken from a list of new and little-tried prescriptions mentioned in one of the last medical journals, which was lying on the old doctor's table. I might as well have got no better under his charge, and should have got off much cheaper.

"The next trouble I had was a little redness of the eyes, for which my doctor gave me a wash; but my wife would have it that I must see an oculist. So I made four visits to an oculist, and at the last visit the redness was nearly gone,—as it ought to have been by that time. The specialist called my complaint *conjunctivitis*, but that did not make it feel any better nor get well any quicker. If I had had a cataract or any grave disease of the eye, requiring a nice operation on that delicate organ, of course I should have properly sought the aid of an expert, whose eye, hand, and judgment were trained to that special business; but in this case I don't doubt that my family doctor would have done just as well as the expert. However, I had to obey orders, and my wife would have it that I should entrust my precious person only to the most skillful specialist in each department of medical practice.

"In the course of the year I experienced a variety of slight indispositions. For these I was aurisected by an aurist, laryngoscoped by a laryngologist, ausculted by a stethoscopist, and so on, until a complete inventory of my organs was made out, and I found that if I believed all these searching inquirers professed to have detected in my unfortunate person, I could repeat with too literal truth the words of the General Con-

fession, "And there is no health in us." I never heard so many hard names in all my life. I proved to be subject of a long catalogue of diseases, and what maladies I was not manifestly guilty of I was at least suspected of harboring. I was handed along all the way from *alopecia*, which used to be called baldness, to *zoster*, which used to be known as shingles. I was the patient of more than a dozen specialists. Very pleasant persons, many of them, but what a fuss they made about my trifling incommodities!

—Oliver Wendell Holmes in the May "Atlantic."

COCAINE POISONING.

Staff Surgeon Hueber communicates to the *Deutsche Militärärztliche Zeitschrift* the notes of a case in which a robust young soldier suffered from severe and prolonged symptoms after an operation for the removal of a nasal polypus, previously to which part of a 2 per cent. solution of cocaine had been dropped into the nostril, the total quantity of the cocaine being certainly not more than a grain and a half. Shortly after the operation the man suddenly lost consciousness, the pulse becoming excessively weak and the skin cold. After being revived by stimulants, he said that he had felt some of the liquid that had been inserted into the nose trickle down the throat, and that this produced a burning sensation, first in the stomach and then in the chest, after which he lost consciousness. The patient did not make a steady improvement, but suffered at times from extreme weakness and quivering of the muscles. He was kept in bed for nearly a fortnight, and did not return to duty for nine or ten weeks.—*Lancet*.

THE TREATMENT OF ALCOHOLISM BY STRYCHNINE.

Dr. Pombrak, writing in the *Medinskiö Obozrenie* on alcoholism, describes seven cases treated by hypodermic injections of strychnine—a method that seems especially in favour in Russia, where,

however, it must be remembered that drunkenness presents as a rule forms somewhat different from those prevalent in this country. Dr Pombrak found strychnine a very valuable remedy, both in cases of chronic alcoholism and in those of dipsomania, not merely curing the attacks, but abolishing the desire for drink. Even attacks of delirium tremens were influenced beneficially. The treatment must be carried out in a systematic manner, and must frequently be kept up for a very considerable period. As to the dose, Dr. Pombrak in cases of moderate severity commenced with one-thirtieth of a grain, in more serious ones with one-fifteenth. He found that while the treatment was being carried out there was no necessity to order the patients to abstain from the use of spirits, as they always did so of their own accord.—*Lancet.*

TRAPPING TAPEWORMS.

“One of the queerest of all queer inventions was patented by a physician. ‘It,’ said the patent agent, ‘was an apparatus for removing a tapeworm from the human stomach.’ It consisted of a silver trap, so arranged as to be sprung like a mouse-trap, by pulling on the bait, and of such form as to be easily swallowed. The patient was to fast several days, until the worm was ravenously hungry, then swallow the trap, which was attached to a silk cord and baited with cheese. The worm, taking the bait, was to be caught by the neck and easily withdrawn through the patient’s mouth. The patent recommends setting the trap again if the first attempt is not successful. The patentee asserted that he had used the device successfully in his practice.”—*British and Colonial Druggist.*—*N. Y. Med. Jour.*

HYPODERMIC INJECTIONS OF CHLORODYNE IN DIARRHOEA.

Dr. Cimballi, of Rome, writing in the *Riforma Medica*, remarks that in serious forms of certain infectious maladies (as,

for example, enteric fever, pneumonia, malaria, &c.), an uncontrollable kind of diarrhoea sometimes occurs, which, besides being a great annoyance to the patient, always aggravates his condition. This profuse diarrhoea, in which the stools amount to twenty or thirty per diem, is usually met with in severe adynamic forms of infectious diseases, and is, moreover, a sign of a highly infectious condition. It is impossible to moderate it either by astringents or by the strongest excitants. In many cases, however, he has successfully employed hypodermic injections of chlorodyne. Fifteen grains of chlorodyne are injected, and if this is insufficient, the injection can be repeated five or six hours later, unless it is one of those diarrhoeas which is the immediate forerunner of the death agony. As a rule, however, after the first injection of chlorodyne the number of stools rapidly diminishes, and the patient experiences great relief. Two or three injections during the twenty-four hours suffice to check, or at least to moderate, them.—*Lancet.*

WASH FOR POST-NASAL CATARRH.

Powdered Chloride of Ammonium . 1 oz.	Common Salt	2 oz.
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A teaspoonful of this in a tumbler of hot water is to be snuffed up the nose twice a day, particularly in those cases where there is deafness.—*L’ Union Médicale*, October 29, 1889.—*North-Western Medical Journal.*

THE RELATION OF THE CORTEX TO VISION.

Bechterew has reinvestigated the whole subject of the relation of the cerebral cortex to vision, and he finds that the area which is associated with vision is very extensive, occupying the whole of the occipital lobe, both on the outer and inner surfaces, and a considerable part of the parietal. In this area are two centres, which to a considerable extent overlap each other. One occupying the part of

the parietal lobe is associated with the corresponding half of both retinae, and the other, which occupies chiefly the parietal lobe, but also in part the occipital, corresponds in function to the whole of the opposite retina. The fact that these two areas overlap so considerably will probably do much towards harmonizing the previous contradictory results at which experimenters have arrived.—*Brit. Med. Jour.*

VENEREAL WARTS.

Venereal warts are very common in women afflicted with gonorrhœa or syphilis. They may be of a soft or hard variety, a difference chiefly due to the amount of moisture to which they are subjected. Generally they are to be found on the vulva, around the orifice of the vagina, but may spread far up into the vagina itself. During pregnancy they grow rapidly. The treatment consists in removing the growths with the scissors or cautery. But they will recur after removal, unless the irritating discharge is checked. If small and seen early, frequent vaginal injections of bichloride of mercury (1: 5000), and by washing the vulva with a solution of 1: 1000 will generally remove them.—*St. Louis Clinique.*

CHEST PAINS.

For the troublesome pains located under the sternum, and elsewhere in the chest, frequently complained of in bronchitis, Dr. M. W. Emerson has found this formula of much value:

- | | |
|----|----------------------------------|
| R. | Sodii Salicylatis |
| | Potassii Nitratis |
| | Pulv. Ipecac. et Opii aa gr. ij. |
| | Fiat capsula . . . gr. j. |

Sig.: Every three hours.—*College and Clinical Record.*—*North-Western Medical Journal,*

THE REMOVAL OF MOLES.

Moles on the face are now being successfully treated by the use of sodium ethylate. The mole is painted with the

sodium ethylate, a fine glass rod being used. When the mole has a varnished look the ethylate is gently rubbed in with the glass rod, to make it penetrate more deeply. The mole turns nearly black and a hard crust forms over it, which is nearly three weeks in becoming detached. When it comes off, the mole is much lighter than before, and this treatment can be continued until the mark is scarcely noticeable.—*Cincinnati Lancet-Clinic.*

SEXUAL NEURASTHENIA.

The coining of the term "neurasthenia" by the late Dr. Beard, seems to me an unhappy one. The picture is so diversified, and so frequently is permitted to cloud the true condition, that I fear much that might otherwise be done is omitted. It is always better that a nomenclature should designate something specific; the more general its significance the less value it will be to those who rely upon others to do their thinking. An examination of our text books will at a glance verify this defect. Thus we find a certain regimen, both therapeutic and dietetic, advised, which an aggregate experience has deemed most suitable and advisable. And yet how frequently have we been disappointed? How much better it would be to seek for specific causes and by relieving them remove the symptomatic expression—the neurasthenic phenomena.—*St. Louis Clinique.*

RELATION BETWEEN ACNE AND DISEASES OF THE NASAL CAVITY.

For several years Seiler (*Jour. Am. Med. Assn.*) has been in the habit of observing that acne became worse with a cold in the head, and gradually disappeared as the cold was cured. Acne punctata is almost always associated with atrophic rhinitis, while acne rosacea is generally associated with hypertrophic rhinitis. Seiler believes that the function of the so-called erectile tissue in the nose is to act as an overflow, and so relieve the congestion in the surrounding

parts. If this function of the erectile tissue is interfered with by disease, congestion of the easily dilated capillaries of the nose, face, and neck may result, and this continued congestion centering round the glandular tissue leads to acne. He believes that this glandular congestion and acne may also result in a reflex manner from nasal irritation.—*Cincinnati Lancet-Clinic.*

THE RESULTS OF CASTRATION IN UTERINE FIBROMATA.

W. Wiedow (in *Beiträge für Geburtshülf'e und Gynäkologie*) reports sixty-six cases of removal of both ovaries with five deaths (7.6 per cent.); four cases of death occurred in the first twenty-four cases. Thirty-seven patients had been under observation for three or more years. In twenty-one case the menopause was established at once; in fifteen, after one or a few hemorrhages. In one case a menopause of $\frac{1}{2}$ year duration was followed by a regular but scanty menstruation. In twenty-four cases the tumor disappeared entirely; in eight it diminished perceptibly, and in one there was no change. The results of oophorectomy being so favorable, Wieder advises the extirpation of myomata only in case of 1, pedunculated subserous or submucous fibro-myomata; 2, fibrotic tumors, and 3, very large tumors.—*St. Louis Clinique.*

HABITUAL USE—OR RATHER USE—OF COFFEE

Is strongly disapproved of by F. Mendel (*Berlin Klin. Wochenschrift*, 1889, No. 40), and he ascribes to its action a complex of diverse symptoms, of more or less serious nature. In contemplating them, we are strongly reminded of a similar attempt of a physician to dispel the favorable opinion which an aged lady entertained of this popular beverage. "Yes, dear doctor," she replied, "I know it to be a very slow poison. I have partaken of it more than seventy years, and, as yet, it has not killed me."

Talleyrand was very fond of it. He took his coffee "black as the devil," "hot as hell" and "sweet as love." He certainly did not suffer from cerebral neurasthenia. Perhaps Dr. Mendel had the substitute—chicory in view when he wrote the quoted article. The mere thought of it gives me the heartburn!—*St. Louis Clinique.*

THE OCULAR MANIFESTATIONS OF LATE HEREDITARY SYPHILIS.

Syme (Melbourne. *Transactions Intercol. Med. Congress of Australasia, Melbourne*), in a short paper based on the analysis of over 100 cases of various eye affections, presumably due to hereditary syphilis, discusses some of the questions in this connection which are yet unsettled. He holds that Hutchinson's opinion that interstitial keratitis is always due to syphilis is more correct than that of many French authorities, who believe it to be a trophic lesion which may be due to several causes, syphilis being the cause generally but not exclusively. Syme says, "Keratitis need not always be due to an inherited taint, however, and some of the cases referred to have been rejected because there was a probability that they were due to acquired syphilis." He would do well to publish his cases of interstitial keratitis in which there was good evidence of acquired syphilis as a cause, for according to all authors they are exceedingly uncommon.

Of 54 cases of interstitial keratitis in which it was possible to decide as to the presence of choroiditis, in 47 this condition was found. Of these 47 patients, 21 were under the age of 12 and 10 under the age of 9 years.

Which of the tissues of the eye appears to be most often affected by hereditary syphilis? Upon this point Syme's cases do not help much. He concludes that the cornea, iris and choroid are all affected in the majority of cases. Are these structures affected simultaneously, or if not, in what order are they affected? The author is of opinion that "in by far

the majority of cases, keratitis, iritis and choroiditis occur pretty much about the same time." In a certain number of his patients he found ophthalmoscopic evidence of old choroidal disease, at a time when the corneal mischief was just beginning. In what proportion of cases this relation obtains is as yet undetermined.—*Ophthalmic Review*.

THE PLACENTA IN ARRESTED PREGNANCY.

Obstetricians have long admitted that portions of retained placenta may remain alive and develop into placental polypi. The growth of the placenta in ectopic gestation after the death of the foetus has been observed by several authorities. Dr. Chaput, of Paris, has reported in the *Bulletin de la Société Anatomique de Paris* two cases where the placenta lived after arrest of normal pregnancy. In the first, abortion occurred at the second month, and the placenta was retained for two months. In the second case the foetus died at the third month, and was retained, with its placenta, for two months longer. The child and its appendages were removed, with fatal results to the mother. Both patients were multiparae, and over 35 years of age. The tissue of the placentæ was examined under the microscope. In each case it was found that the placenta had neither atrophied nor continued to develop as in normal pregnancy. A singular abnormal development was detected. The villi had decreased greatly in number, and lost their vessels; on the other hand, those which remained were from double to ten times their normal size, and contained numerous cells, some very large, without distinct nuclei. The villi retained an epithelial lining. Dr. Chaput takes care to remind his readers that although science proves that retained placenta does not necessarily die and decompose, the results of retention are not on that account less serious. But his cases suffered severely, with most of the usual symptoms. His observations, he further insists, do not prove that the

placenta can go on developing indefinitely; nor can we feel sure that it will perish by gradual atrophy rather than by more or less sudden decomposition. In all cases a retained placenta ought to be removed.—*British Medical Journal*.

THE PRESERVATION OF OUR FORESTS.

The Adirondack Park Association has been permanently organized for the laudable, almost religious, duty of preserving the "north woods" from further degradations. Dr. Alfred L. Loomis has been elected president, and Dr. Martin Burke, secretary. Nearly all the officers are residents of New York, and, with the exception of the two above-named, are from among our merchants and lawyers well known in every spirited undertaking. We think that the future of the great State park can be assured through the efforts of this notably influential body of citizens. The cause of forestry, in its health relations, has received a help in recent action taken by the National Conference of State Boards of Health, at Nashville, in the adoption of resolutions declaring in favor of the preservation and cultivation of forests. The position taken by the promoters of this action is that floods and cyclones, which are becoming more and more frequent and destructive of life, are due mainly to the cutting down of forests. Thus we see that the conservation of the Adirondacks and other wild woods partakes in a reform that is national in its scope, and it is eminently proper and fit that the medical men of the country should be found in its vanguard.—*New York Med. Jour.*

SUCCESSFUL NEPHRECTOMY IN A YOUNG CHILD.

In February, Professor Dohrn removed from a child aged 3 a large malignant tumor involving the right kidney and suprarenal capsule. The child was in fair health, but rather pale; there was a trace of albumen in the urine, but no formed elements could be detected under the microscope. The veins in the parietes over the tumor were dilated; the inguinal

glands were not enlarged. The tumor was extracted through an eight-centimètre incision, beginning at the outer border and running obliquely downwards towards the iliac spine. The operation was difficult, owing to the softness of the tumor. The patient made a very good recovery. The tumor proved to be a rhabdo-myosarcoma of the kidney, consisting of round cells and spindle cells, with here and there collections of striped muscular fibre. Eberth, Cohnheim, Eve, and Dawson Williams have described similar new growths of the kidney, which Cohnheim ascribed to errors in foetal development. Professor Dohrn, in an article in the *Centralblatt für Gynäkologie*, No. xvi, 1890, describing his case, adds that extirpation of the kidney in children has only been attempted in recent days. Fisher collected last year 25 cases where that operation had been performed; the mortality was 48 per cent. Professor Dohrn has added to the record his own case, and others recorded within the last twelve months by Schede, Czerny and Roberts, making up a total of 29 cases, with an "operation mortality" of 44.9 per cent. Professor Dohrn's case was alive and well two months after the operation.—*Brit. Med. Jour.*

ALKALOIDS IN THE DISEASES OF CHILDREN.

Dr. Daniel Morton (*Saint Joseph Medical Herald* April, 1890), not relying on the inaccurate Galenical preparations of the pharmacopœia for children, suggests the use of the alkaloids, and he concludes that they offer an improved method of prescribing drugs to children, because they are absolutely accurate in dose, pleasant, safe and easy of administration, and will certainly accomplish the purpose for which they are given.

Medical Items.

The City Council has appropriated \$4,000 for a morgue.

"The position of Health Officer should be a career, not an episode."

The *Medical and Surgical Reporter* has discovered an abortionist at Easton, Pa.

The new Newberry Library in Chicago will have one section for medical works and journals.

The *Texas Health Journal* deserves credit for driving out the irregular practitioners from the State.

Dr. J. W. McSherry, of Martinsburg, W. Va., was elected Mayor of that city recently.

The Lone Star Medical Association (of colored physicians), held their fifth annual meeting in Galveston, Texas, June 3.

On April 20th, Professor Liebreich, of Berlin, celebrated the twenty-fifth anniversary of his graduation as Doctor of Medicine.

The first Chinaman ever graduated in medicine in this country, Joseph Chak Thoms, has received his degree at the Long Island Hospital College.

The Association of Medical Editors elected Drs. F. L. Sim, President; Frank Woodbury, Vice President, and J. C. Culbertson, Secretary and Treasurer.

Dr. Samuel H. Martin, a retired physician of this city, and a graduate of the old Washington University in 1844, died at his residence, 1109 McCulloh St., last Saturday.

The Medical Record says that a soldier who had borrowed a bugle belonging to a musician who was suffering from tuberculosis became himself a victim to this fatal disease.

A new association for the promotion of medical science has, on the initiative of Dr. N. Russkich, been founded at Ekat-

erinburg, in Asiatic Russia, under the title of "The Ural Medical Society."

The *Medical Record* says that the doctor who begins to investigate the "baby food" upon the market, will find his mind in a delicious whirl through unexceptionable and emphatic medical testimonials.

The French Minister of Commerce, acting on the advice of the Department of the Seine, is about to introduce a Bill prohibiting the use of sewing machines worked by pedal by girls of less than 16 years of age.

Profesor Leber, of Göttingen, has been appointed Ordinary Professor of Ophthalmology and Director of the Clinic of Eye Diseases in the University of Heidelberg, in place of Professor Otto Becker, whose death was recently announced in these columns.

Professor Horatio C. Wood, M. D., of Philadelphia, has been chosen by the General Committee of the International Medical Congress to represent American medicine in the delivery of one of the addresses before that body. A well-deserved honor for the man and the country.

The Eastern Dispensary pays its staff each \$200 a year, and they are appointed after a competitive examination. The Baltimore General Dispensary, a worthy and venerable institution, also pays its staff \$200 a year each, but the appointments are made principally through influence.

At a recent meeting of the Liverpool Medical Institution the following resolution was adopted: "That in the opinion of this meeting it is desirable that the physicians, surgeons and medical officers of all non-medical charitable institutions should receive some pecuniary recognition of their services."

An old Belfast sea captain is credited with devising a unique barometer. It consists of a thin strip of white pine with

a number of cross pieces upon it. This is hung on the side of the building, and when damp weather is approaching the barometer bulges out in the centre, while in dry weather it sinks in.

Dr. F. Christian Faye, for many years Professor of Medicine in the University of Christiania, died on the 5th inst., aged eighty-four. Besides his high reputation as a consultant in the diseases of women and children, Professor Faye had the credit of having founded in 1858 the Academy of Sciences at Christiania.

H. R. H., Duke Carl Theodore of Bavaria is a regular graduate of medicine and a skilful oculist. He has done much gratuitous practice in hospitals and among the poor, and it is said that his presence in the hospital upsets the orderly arrangements, as everything has to give way to Royalty. In practising among the poor he probably deprives some poor practitioner of a fee.

At the last meeting of the American Surgical Association the following officers for the ensuing year were elected:

President, Dr. Claudio H. Mastin, Mobile; *Vice-Presidents*, Dr. J. Collins Warren, Boston, and Dr. Stephen Smith, New York; *Secretary*, Dr. J. R. Weist, Richmond, Ind.; *Treasurer*, Dr. P. S. Conner, Cincinnati; *Recorder*, Dr. J. Ewing Mears, Philadelphia; *Member of Council*, Dr. Stepen H. Weeks, Portland, Me.; *Chairman Committee Arrangements*, Dr. John S. Billings, Surgeon U. S. A. The place of the next meeting is Washington.

The duty on cod-liver oil is now \$2.25 per barrel. The McKinley Tariff Bill proposes to raise this to \$5.00 per barrel. A large number of importing and manufacturing druggists have signed a protest against the proposed increase and ask that the duty be taken off altogether. Cod-liver oil cannot, it is stated, be manufactured in this country in sufficient amount to supply the demand because there are not enough cod.

According to the *Medical Record*, it seems that the McKinley Tariff Bill has made "an insidious thrust" at the imported fluid extracts of beef. According to the *International Journal of Surgery*, the bill in question contains a clause which will in effect prohibit the importation of fluid extracts of beef. Is it only a coincidence that about this time Mr. Armour is putting a preparation on the market?

There was recently raised, in New York, a question in connection with fees demanded for filling out death certificates in cases where litigation is a possibility. A patient died in the Bloomingdale Insane Hospital on whose life there was \$20,000 insurance. The physicians of the asylum, it is said, refused to sign the certificates unless paid one-half of one per cent. of the insurance.

In view of the large number of phthisical patients using the *wagon-lits* on the French railways on their way to the South, it is proposed to adopt measures for the thorough disinfection of the bedclothes, etc. The velvet cushions and silk hangings are to be done away with, and the seats are to be covered with smooth leather, so that they can easily be washed. Carpets are to be replaced by rugs, which can be shaken in the open air after each journey. The bedclothes are to be subjected to the action of heat in vapour stoves, and the mattresses are to be covered with impermeable silk or gutta percha tissue, so that they can be readily cleaned. The invalids will travel in separate compartments, and each of them will be provided with a spittoon, which can be emptied outside the carriage.

By direction of the Secretary of War the following-named officers of the Medical Department will proceed to Berlin, Germany, as delegates to the International Medical Congress. Lieutenant Colonel Charles H. Alden, surgeon; Major John S. Billings, surgeon. After

the adjournment of the Congress the officers named will return to the United States and rejoin their proper stations.

Major John S. Billings, surgeon, will, while abroad under his orders to attend the International Medical Congress at Berlin, Germany, and before returning to the United States, visit, on official business, such points in Great Britain, France, Italy, Germany, Belgium, Holland, and elsewhere, as may be deemed necessary by the Surgeon General of the Army, and under such special instructions as he may receive from the Surgeon General.

At a meeting of the National College Association held at Nashville, the following officers were elected: *President*, N. S. Davis, Chicago; *First Vice-President*, Aaron Friedenwald, Baltimore; *Second Vice-President*, H. N. Didama, Syracuse, N. Y.; *Third Vice-President*, T. Menees, Nashville; *Fourth Vice-President*, Sam Logan, New Orleans; *Fifth Vice-President*, W. H. Pancoast; *Sixth Vice-President*, C. A. Lindsay; *Seventh Vice-President*, W. T. Peck; *Secretary and Treasurer*, Perry H. Millard, of St. Paul, Minn. The business committee recommended that all the colleges of the Association adopt a three years graded course; that the examination be both oral and written; that laboratory instruction in chemistry, pathology, and histology be required; that an admission examination be held, and that the secretary of each college transmit to the secretary of the Association a list of all the matriculants in his institution, together with a copy of the questions asked at the examination for admission. At the general session of the American Medical Association on Thursday, the secretary of the College Association presented a report setting forth in detail the rules adopted by the Association, which report was accepted with expressions of hearty approval by the general body.

Dr. T. More Madden has received from the Texas Medical College the honorary degree of Doctor of Medicine.

MARYLAND MEDICAL JOURNAL,

VOL. XXIII. No. 7. BALTIMORE, JUNE 14, 1890.

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THE MUTUAL RELATIONS OF THE HEALTH DEPARTMENT AND THE MEDICAL PROFESSION.*

BY J. D. BLAKE, M. D.,
OF BALTIMORE.

Mr. President and Gentlemen:—I desire to say, at the very outset, that I have a very high regard for the personal and professional worth and standing of the Health Commissioner and his able assistant, and I respect every man employed in the department, *as men*, entitled, so far as I know, to the respect of the community, and a few of them as capable of filling the positions they hold as any that can be secured.

And what I shall say to-night will be what I consider a legitimate discussion of

the relations of the Health Department, as a department, and its officers, as officers, and not private citizens, to the medical profession.

As only a part of the officers of this department come in contact with the medical profession in the performance of their duties, I shall consider the *Health Department* as consisting of Health Commissioner, Assistant Health Commissioner, Vaccine Physicians and Sanitary Inspectors.

According to the best lexicographers, the word *mutual* is defined as expressing a reciprocal, or condition of interchange, such as reciprocal or mutual assistance, one aiding and assisting the other in a manner that is agreeable to both.

A very natural query is just here forced upon us, viz.:

Does such a mutual condition exist as above defined between the Health Department and the medical profession? If not, why not? In answering this question, I shall attempt to show that such a condition does not and has not existed,

*Read before the Clinical Society of Maryland May 2nd 1890.

and that the laws under which the Health Department has its existence are so unjust and impracticable in many instances that their enforcement is not only impossible, but a feeling of contempt both for the law and Department is created by any attempt to put it in force.

I have been surprised that former commissioners have not strenuously advocated the repeal and re-enactment of these laws long ago. A reference to a few sections from the City Code will satisfy you on this point.

Duties of the Health Commissioner: "It shall be the duty of the Commissioner of Health to inspect, at least once in every two weeks, between the first day of March and the first day of November, in every year, and at such other periods as the Mayor may direct, all the streets, lanes, alleys, wharves, warehouses, cellars, yards, lumber yards, lots and docks of the city, and all other places he may deem necessary, and make a written report to the Board of Health of the general state of the city, and to enforce all laws and ordinances having any relation to health, and to remove or cause to be removed all nuisances.

It shall be the duty of said commissioner carefully to inspect all lots, grounds, suspected cellars or possessions, and all streets, lanes or alleys within the city, and whenever he shall be of opinion that any cellar, lots, grounds or possessions within the city are in a state of nuisance, or so situate that in warm or unhealthy seasons a nuisance may be thereby created, and the health of the citizens endangered, it shall be his duty, and he is hereby authorized to cause a notice to be served on the owner or owners, occupier or occupiers, or his, her or their agent, directing him, her or them to have said nuisance, or cause of nuisance, removed, in the manner prescribed in such notice; and if such owner or owners, occupier or occupiers; or his, her or their agent or agents, shall neglect or refuse to comply therewith, he, she or they so refusing or neglecting, shall forfeit and pay not less than ten, or more than twenty dollars,

and the further sum of five dollars for each and every day he, she or they shall continue to neglect or refuse to comply with said notice, and shall moreover pay the expenses incurred in case such nuisance or cause of nuisance shall be removed under the directions of the Commissioner of Health, which the said commissioner is hereby authorized to be done in case of such neglect or refusal."*

This is not more absurd than the law which the Health Commissioner is bound according to his oath to have the Vaccine Physicians execute, and which is as follows:

Duties of Vaccine Physicians: "There shall be annually appointed, as other city officials are, a vaccine physician for every two contiguous wards, who shall be a resident of one of the wards for which he may be appointed, if practicable, who shall vaccinate in his wards all such persons as may be pointed out to him by any member of the Board of Health, as susceptible to small-pox contagion, and whose duty it shall be to visit each dwelling-house in the wards, and vaccinate every person who may be presented to him for that purpose, and to be prepared at his office, at such hours as may be designated by the Commissioner of Health, to vaccinate all who may there call on him that are residents of said wards, requiring that operation; and said physician shall enter upon the performance of the duties prescribed by this section immediately after his appointment. And it shall be the further duty of the vaccine physicians to keep a record of the names, age and residences of all whom they may vaccinate or re-vaccinate, and report the same monthly, under oath or affirmation, to the Board of Health, and to preserve, at all times during their term of office, all pure vaccine crust which may come into their possession, and deposit it at the health office once a month, carefully enveloped and marked with the date at which it was taken from the arm; and it shall further be their duty to report

* Baltimore City Code Page 388, Article XXIII, Sections 14 and 15.

monthly to the Board of Health the names of all persons who shall refuse to suffer themselves or members of their household to be vaccinated, when the same shall be necessary."**

Now, the latest estimate places the number of dwelling houses in the city at 70,000, which would give each Vaccine Physician 5,833 houses to visit during the year, or about 18 to 20 every working day, not excepting holidays; besides this, he is to sign all certificates of vaccination for the public and private schools, as well as contagious disease certificates, and during epidemics he has to visit for the Sanitary Officer all cases reported by the police as suspicious in order that they may be properly diagnosed, and to perform such other duties as the Health Commissioner may from time to time require, for which he is to receive the enormous sum of \$300!

Here comes a point in which I am much interested: The Health Commissioner, when reading his last paper on this subject to this society, assured us that he desired to see the law carried out to the letter, and he urged all to comply with it at once. He also gave us to understand that the Department would not fail to enforce the law whenever he knew it was violated, if he had sufficient evidence of that fact, and I believe he means every word that he utters, and I am sure he desires a faithful compliance by the profession, but he ought to be sure that it is possible to do so before he declares that he will. Indeed, he has taken an oath to carry out the law, yet I know it is simply impossible for him to do so. I am sure he does not desire to enforce it against others and ignore that which applies to himself or his office.

It will be quite a surprise, I am sure, to the vaccine physicians when they report June 1st for their first quarter's salary, to find that this decision will deprive them of their first earnings under the new administration, unless they (as I know they cannot), show that one-fourth of the houses in their entire district have

been visited during the present quarter, for the law is as follows:

"Before the vaccine physicians shall receive their first quarter's salary, the Commissioner of Health shall be satisfied that they have called at one-fourth of the houses in their respective wards, and the second quarter's salary shall not be paid until one-half of the houses have been visited, and so on through the year, and a proper return of the same made; their salaries only to be paid on the endorsement of the Commissioner of Health."†

And unless the Health Commissioner is able to satisfy the Mayor on this point, he will not be able to draw his own salary.

Mayor's duty.—"The quarter's salary of the Commissioner of Health shall not be payable until the Mayor shall be fully satisfied that the preceding two sections have been impartially carried out."‡

Do such laws as these tend to excite respect, or a desire to even try to live up to them, or do they tend to create a feeling of indifference and opposition?

Such, I am afraid, will be the effect of the last law that has been given us, in regard to contagious diseases. If physicians were required to report all such diseases as a matter of statistics only, I can see no harm in it, but when we know that such a notice will bring an officer of the Department who, nine times out of ten, will serve no other purpose than frighten the nervous and anxious mother, and other ladies of the house, without any benefit to either patient or Department. I can see no good in it. Who, in such a case, would take more interest in the sanitary surroundings of the patient than his physician, or the parents themselves, who eight times out of ten are as capable in this direction as the officer himself?

Therefore I feel constrained to say, that my experience with the profession leads me to conclude that such laws tend to strain the relation between the Department and the profession, rather than make them mutual.

*Loc. Cit. Page 421, Article XXIII, Section 119 and 120.

†Loc. Cit. Page 422, Article XXIII, Section 121,

The Sanitary Officer.—Who is he? Ordinarily he is a quiet inoffensive man in his way, and if left to follow only those occupations which his previous training best fits him for, would be quite harmless, but when called by reason of active service in party politics, to adorn himself with the regalia of the Health Department, then he becomes a formidable power in the land.

And just here I want to say that as long as the Health Department is run as a political office, where ward politicians without regard to any sort of qualification save a political one, are rewarded for party service, by being placed in the responsible and all important positions of Sanitary Officers, positions in some respects and at certain periods, hardly second to that of Commissioner of Health and certainly requiring as much information in regard to sanitation and laws pertaining to health and disease, the effects of germs &c. upon the system, we can not expect anything that looks like mutuality to exist between the Department and the profession.

When we take into consideration the fact that these officers are often taken from the *minor avocations* of life, ill prepared intellectually, to fill the most menial positions, and elevated to the important and responsible position of Sanitary Officers, which in many instances confers upon them the entire power of the Health Department, including the power, if in their wise discretion they think proper, to take charge of a family or patient, and dispose of it, disregarding any opinion or any directions that the family physician may have given, is it any wonder that these men, when they find out what unlimited power they have, feel their importance to an exaggerated degree, often pushing their authority to an appalling extent, causing great alarm and indignation at times on the part of the laity, and disgust on the part of the profession, who feel in turn that such acts not being rebuked by the head of the Department, that these men fully represent the entire Department,

and for that reason the health authorities as a department should be looked upon, to say the least, with suspicion?

Penalties for obstructing the Board.—“If any person shall knowingly obstruct or resist the Board of Health, or any member thereof, or any person by them appointed, in the execution of the powers to them given, or in the performance of the duties enjoined on them by this or any other ordinance in relation to the public health, such person shall forfeit and pay a sum not exceeding two hundred dollars.

If any person or persons shall refuse or neglect to comply with any order or notice of the Board of Health, authorized by any section of this article, and no other penalty is herein provided for such neglect or refusal, such person or persons shall forfeit and pay the sum of twenty-dollars for each offense, and five dollars for every day that such neglect or refusal shall continue. §

I know that there is an impression in existence that the Sanitary Inspector's duty ends when he has visited the premises and reported his finding to the Commissioner of Health. This is a mistake. Upon his report he is often required to take entire charge of the *patients* and *premises*, and to deal with it as his sanitary judgment dictates; this may be denied, but not successfully so, for I have known personally in epidemics and at other times, when contagious diseases existed, Sanitary Officers to enter the premises and go through the form of disinfecting, and giving the family orders in regard to their use, as well as attempting to regulate family intercourse, &c., &c., at the same time a physician was in attendance upon the sick, and he often found his instructions in this direction laid aside because the health officer had laid such stress upon his own orders, and given the parties to understand that nothing was genuine that did not emanate from the Health Department which he so fully and intelligently represented.

How can it be otherwise? Is there any one here to-night who is foolish enough to think that the Commissioner of Health and his Assistant could give personal attention to one case in a thousand in the ordinary run of contagious diseases, much less in times of epidemics, when skill and intelligence on the part of the officers in charge will have much to do with the recovery of the patients and protection of the community? Hence, I say that it often happens that a case is not heard from at the office except when reported by the doctor and the final report of the inspector is made, and this must be so under the present law, and if so, should not the intelligence of the whole department be reflected to a great extent in each officer, who is entrusted with the all important duty of inspection and removal if necessary, and especially in the disposition of furniture, &c.

A case or two will illustrate my meaning. A case of small-pox exists in a small street; the patient in the suppurative stage is removed to the hospital under the direction and supervision of the inspector; while men are down stairs sprinkling *phenol*, others are in the third story removing the windows and throwing the very bed and bed-clothes out of which the patient came, upon the pavement below, at the same time quite a respectable audience as to size, made up of men, women, and children are interested spectators upon the opposite pavement about ten feet away.

Again, these officers have been known if they told the truth, to leave such work and place and board the first street car that was passing in the direction in which they were going, and boast in the presence of passengers of the many small-pox cases they had visited during the day, no doubt an honest desire on their part to amuse and enlighten the stupid passengers, but the result was different.

Again, small-pox and other diseases have been reported by physicians to the Department and a Sanitary Officer has visited the house and patients, and re-

fused to confirm the doctor's diagnosis, and instead has given an opinion that it was not small-pox, which caused great excitement on the part of the family and made the doctor feel like saying something bad, but instead, called another physician in, when the diagnosis of the doctor was confirmed.

It has been a most remarkable experience with me to find that our former Commissioners seem to place unbounded confidence in the positions taken by Sanitary Inspectors, and it usually took considerable effort to get such opinion as he expressed reversed by the chief of the Departments. Especially was this the case if there happened to be any politics in it. Then, surely, were it easier for a camel to traverse the foramen occupying the large end of a needle.

To illustrate: an humble and quiet citizen, living on the very edge of the city, on the B. & O. R. R., had a pigpen built near the track of said road. One day the rail-road officials were passing over that part of the road, when an unfavorable wind (for the rural citizen), caused the odor of said pen to be wafted toward the rail-road officials, whose sensitive olfactories became greatly offended, so much so, that the Health Department was at once notified of the existence of said pen and the offence it had given (the B. & O. R. R., as a political factor, you know, is not to be despised), and in a very short time the above mentioned citizen was ordered to abate the nuisance; and before it was possible for him to do so, he was promptly arrested by order of the Department and taken before a magistrate, while at that very time and since then, city officials and others were violating every law known to the Department for the prevention of nuisances, and dumping manures, vegetable and animal matter in enormous quantities in a much more populated part of the city, and the Department was appealed to time after time by the *humble but honest* residents of the section invaded, who asked, in the name of justice, that it interfere and protect them from the malarial poison that

was then arising from this mountain of filth that was being placed there by men who had sworn to obey the laws of the State and city (both of which prohibited it), and family after family was being prostrated by it. I, myself, in my efforts to suppress it, found the most deplorable condition of things to exist at the City Hall, notwithstanding the fact that I had taken the Assistant Health Commissioner to the place, where he saw for himself several loads of the vilest material dumped while we were on the spot. He pronounced it an unmitigated nuisance, one fraught with much danger to the inhabitants of that section, and he so reported it, but nothing was done, until I appealed to Mayor Latrobe, and went before the grand jury and had one of them indicted. Why such promptness in the B. & O. case and such fearful and dangerous lethargy in the other? I answer, Politics, —and this, gentleman, is only one of many thousand cases which from time to time have disgraced this Department. This brings us to consider another very important question, viz.: What do we mean by the term "politics" and who is responsible for its existence in the Health Department? You would be inclined to say the Health Commissioner, but I beg to differ with this view of it and to say that the medical profession, an intelligent body of men, are responsible, *and my word for it*, unless we, as a profession, get rid of the idea that our duty as good, law-abiding, tax-paying citizens ends when we have attended to the few patients allotted to our care, and have nothing to do with the legislation that is enacted, or offices created and filled by incompetence under the pretense of protecting public health by giving simply a professional nod of assent to what is done in this direction, thus really becoming a party to the outrage, we need expect no reform in this direction, for without the aid of the profession in a practical and substantial way, consulting with and making ourselves felt in this direction, we need not expect anything of value to result from the administration of our worthy and very efficient Health

Commissioner. While I recognize the fact that he can be a power for good in this direction if aided and assisted, yet without this his proclamations and suggestions will be as sounding brass and tinkling cymbals, if it proposes to interfere in the least with the idea of the practical politician as to running a department for spoil's sake, and also with a view of making it more or less healthy for a few of his satellites. "Oh," you will say, "the *Health Commissioner* should prevent all this sort of thing." What is the inducement for him even to try to do so? for he knows very well (and if he does not, I will tell him), that if he makes any attempt to reform the Health Department, by which the plans and friends of the practical politician are interfered with, he will very soon be told what his fate will be, and they will see that he goes, while the medical profession, his own brethren, are standing on so much dignity that they cannot consent to assert their opinions and rights and see that he is sustained in any honest effort he may make. Thus he muses on this subject: "If I do as my political friends say, I stay; if I do as I think best for the people and science, I go. Why? Because, if I do as the politician desires, I am called on, *thanked*, and when the time comes, *sustained and retained*; on the other hand, if I do as I think best for the whole community, and I am accidentally met by one of my brethren, I am slightly congratulated, and if I am (as I will be), left out of the green bag at its next excursion to the Council, my professional brothers will simply content themselves by shedding a few crocodile tears, and lamenting in a quiet way the loss sustained by a great city."

The Commissioner then concludes that the law of self-preservation is the one that meets the demands of his case, and he stays. This is what we mean by politics in a department.

Again, the object of maintaining a Health Department, it seems to me, is, 1st, the improvement of the sanitary condition of the city, by hunting up and investigating the particular evils which

from time to time threaten the health of the community, and 2nd, the more general, and perhaps more important, object of educating public opinion as to the necessity for sanitary reforms, and thus by reflection lead our legislators to pass such laws as will be necessary to enable the department to carry out proper reforms. In order to do this, it seems to me that those who are entrusted with the important duty of investigating such conditions, and are thereby thrown with the individual citizen and medical profession, should be men capable of imparting such information as will educate the public to their duty in this matter. *Is this the case?* Does the Sanitary Inspector possess such knowledge? Are they capable of teaching people sanitary matters—can they explain to them the necessity of their becoming interested in the matter of sanitary reforms, and thus assist the family and the family physician in the work in which they are both interested and in the performance of which they are so often brought in contact with the profession? I answer, No, they are not capable, and it is on account of this incapacity that the medical profession is so often brought into undesirable contact with the Health Department. Who are these men, and what has been their previous training for these responsible positions? In the *past*, as *now*, they have been taken from various trades and occupations, such as clerks, mariners, glassblowers, ex-barkeepers—quite a contingent from this source—gilders, and last, but not least, the active party worker with no special occupation or trade. Is it any wonder that the relations existing between the Health Department and the profession are not mutual, under such circumstances? Can they ever be? Is it not a burlesque upon our civilization? If you want a carriage built, do you get a bricklayer to do it? If you want a case tried in court, do you call on a shoemaker? even if you desire an assistant to a regular attorney, how would they pull together at the bar? Yet, when you want the public educated as to sanitation, and want

unsanitary conditions treated in a sanitary way, we call *not* on them who have laid a foundation for such study and work, but upon clerks, glassblowers and saloon keepers, &c., going upon the theory I suppose, that if they saved the party, they will save the people also.

I do not refer specially in these remarks to the present members of the Sanitary Force, but covering a period of many years, up to this time the rule laid down above holds good.

Nor do I wish it to be understood that I underrate the value of many of these men as private citizens, and I go further and say, were I in their place I would accept the very positions that they do, were they offered, but it is to the law that permits such appointments (and by the way I will say that I have never been able to find any authority for the appointment of Sanitary Officers), that I wish to call your attention, not for the purpose of trying to underrate what has been done in the past, but that we may assist the present and future Commissioners in regulating and reforming the Department in the future.

We often find it very easy to criticise and very difficult to offer a remedy, but I think I can suggest some plan that I know will work better than the present and bring about a feeling between the Department and the profession that will be entitled to be called a mutual relation, and the cost will not be much greater but the benefit will be immensely so.

We have now 8 Sanitary Inspectors, \$1000 each - - - \$8000.

We have now 12 Vaccine Physicians, \$300 each - - - \$3600.

----- \$11,600.

Our Health Commissioners have always advocated thorough vaccination, and re-vaccination, and claimed that if this was thoroughly performed annually, we would not witness an epidemic of small-pox every ten years, the cost of which to the city can not be estimated; if this be so, why make its accomplishment impossible by keeping in force such laws as we have at present.

Suppose, in their stead, something like the following law be enacted.

“Be it enacted and ordained by the Mayor and City Council of Baltimore, that there shall be annually appointed, as other city officers are appointed, three physicians for each ward in the city, who shall be known as the vaccine and sanitary physicians for their respective wards, and who shall be residents thereof.

And be it further enacted and ordained that after the appointment and confirmation of said physicians, the Mayor shall select in each ward one of the three appointed as aforesaid, who, when thus selected and designated by the Mayor, shall become a member of the Board of Health; and the several physicians thus selected by the Mayor, one from each ward, shall, with the Commissioner of Health and the Assistant Commissioner of Health, constitute the Board of Health for Baltimore city, whose duty it shall be to cause to be executed and observed all ordinances for the preservation of the health of the city.

And be it further enacted and ordained, that said vaccine and sanitary physicians shall be appointed for one year, and shall each receive an annual salary of three hundred dollars, payable quarterly.

And be it further enacted and ordained, that the physicians who shall have been selected, as aforesaid, by the Mayor as members of the Board of Health, shall divide their respective wards into three districts of three election precincts each, and assign to each of said districts one of the three vaccine and sanitary physicians for the ward in which such district is located.

And be it further enacted and ordained, that it shall be the duty of said vaccine and sanitary physicians to visit annually every house within the bounds of their respective districts, established as aforesaid, and vaccinate all persons who, in their judgment, shall stand in need thereof; that they shall remain in their respective offices, to be located in their respective districts, during such

hours of each and every day as shall be determined by the Board of Health, for the purpose of vaccinating any persons who may there present themselves for that purpose. They shall keep a record of all persons vaccinated by them, giving name, residence, age and color of patient, and whether the vaccination was primary or secondary, successful or unsuccessful.

And be it further enacted and ordained, that hereafter no vaccine physicians or sanitary inspector shall be appointed by the Mayor nor employed by the Health Commissioner, nor shall there be employed by the Health Commissioner any assistants, other than for purely clerical work in his office, except such sewer inspectors as have been heretofore appointed; provided, that the vaccine physicians who shall have been heretofore appointed for any of the several wards in the city shall hold their respective offices until the vaccine and sanitary physicians for their respective wards shall have been appointed and confirmed hereunder.

And be it further enacted and ordained, that the Board of Health, constituted as herein provided, shall be and is hereby substituted for the Board of Health as now constituted, and is hereby clothed with all the powers and duties which, by the statutes of the State of Maryland and the ordinances of the city of Baltimore, now devolve upon the Board of Health.

And be it further enacted and ordained, that the said vaccine and sanitary physicians shall, subject to the supervision of the Health Commissioner, have charge of all cases of small-pox, varioloid, cholera, yellow fever, malignant diphtheria or scarlet fever within their respective districts, when the patient is not attended by some other responsible physician; they shall superintend all removals of persons suffering from small-pox; shall have destroyed all bedding and clothing of all sorts which have been used by small-pox patients and shall have promptly and properly fumigated and disinfected all houses from which persons have been removed who

have suffered or died from small-pox.

And be it further enacted and ordained, that all ordinances and parts of ordinances inconsistent with the provisions of this ordinance be and they are hereby repealed."

The difference in the cost of such an efficient department as this, would be very insignificant, directly, and indirectly decidedly cheaper than the present system. Who of us can estimate the cost of an epidemic to this city, and if vaccination and sanitation will prevent it, I believe this will give it to us, and at the same time bring the Department into a decidedly mutual relation with the profession.

AN INTERESTING CASE OF FRACTURE OF THE VAULT OF THE SKULL, EXTENDING INTO THE BASE.

BY SHELDON G. EVANS, M. D.,

Resident Physician at St. Joseph's Hospital,
Baltimore.

D. P., male, aged 37, native of Italy, was working in the hold of a vessel, unloading iron ore, when the bucket containing the ore was accidentally overturned at some distance above the workmen and a portion of its contents struck him on the head; as far as can be learned, the patient did not lose consciousness at the time of the accident.

He was admitted to the hospital, and an examination revealed a small, lacerated wound, about an inch in length, over the posterior portion of the right parietal bone; also a small incised wound, apparently insignificant, a little above and anterior to the preceding; a linear fracture of the skull could be made out under the posterior wound, but no depressed bone could be distinguished; and as the patient showed no evidences of cerebral compression, but merely those of

severe shock, a trephining was not considered necessary or justifiable.

A portion of the head was shaved, the wounds thoroughly washed, stitched and dressed, under antiseptic precautions, and ice was applied to the head; small doses of calomel were administered at frequent intervals, until the bowels were freely evacuated. The patient was perfectly rational and fully conscious, and appeared to be suffering little pain. The shock, however, was severe, the temperature registering 96.5° and the pulse being 52.

On the day following the receipt of the injury, the patient showed signs of cerebral irritation, lying coiled up in bed on one side, usually the left, eyelids firmly closed, pupils contracted, skin cool and pulse 54, small and feeble; mental irritability was marked, the patient being apparently angry and sullen when aroused, but remaining quiet when undisturbed, although occasionally he became somewhat excited, but was soon quieted by a full dose of bromide of potassium. The application of the ice cap was continued, and all sources of irritation possible removed. At this time slight internal strabismus could be noticed in the left eye, and pupil was somewhat sluggish, but these slight evidences of compression were not deemed sufficient to justify an operation.

On the evening of same day, the patient's general condition was unimproved and the strabismus, etc., was somewhat increased, and slight paralysis of the palpebral muscles could be detected. On the next morning, or second day after the accident, strabismus and other evidences of compression had so much increased that an operation was deemed advisable; but while preparations were being made for the operation, severe symptoms suddenly developed, the patient lost consciousness, and died in a few minutes.

A post-mortem examination 23 hours after death, revealed scalp infiltrated with blood to an extreme degree, and a large Y-shaped fracture of the skull, one

arm extending from the parietal protuberance on the right side, transversely across the vault of the skull, nearly parallel to the coronal suture, and extending for the distance of about one-half an inch into the squamous portion of the temporal bone on the left side.

On the right side the fracture extended with the orbit and the posterior limit of the fracture reached the occipital protuberance. On removing the skull cap, which fell into four pieces when removed, large clots were found between the dura mater and bone, along the line of the fracture and one-half inch to either side of it.

The meninges were somewhat thickened and hyperæmic; but not adherent except to a slight extent on each side of the great longitudinal sinus; cortex somewhat congested.

The fracture extended into the base, involving the great wing of the sphenoid bone on the right side.

The starting point of the fracture was apparently beneath the anterior or smaller wound, at which point it was somewhat comminuted. The temporo-sphenoidal lobe of the brain on the left side was slightly lacerated, evidently by *contre coup*, as no evidences of direct injury could be discovered at that point.

The interesting features of this case are numerous; first, the lack of unconsciousness until one hour before the fatal termination, notwithstanding the extensive area of the fracture, involving almost the whole vault and a portion of the base of the skull.

Secondly, such slight evidences of compression in spite of the large clots found between the dura mater and bone.

Thirdly, the fracture extending into the orbit and there being no sub-conjunctival haemorrhage or protrusion of the eyeball.

Lastly, the life of the patient being prolonged for two days with such a great amount of injury to the brain.

A SUCCESSFUL CASE OF TRACHEOTOMY WITH IMPROVISED TUBE.

BY W. FRANK HINES, M. D.,
OF CHESTERTOWN, MD.

On the morning of Wednesday, May 14th, 1890, I was called to see the fifteen months old child of Mr. K. I found the little one moving about the house in its night-clothes, with croupy cough, but little or no distress in breathing. After examining it and directing an emetic, if necessary, and ordering a stimulating expectorant, I left at 9 o'clock.

Upon my return from the country at 12 o'clock, I found a message to go to Mr. K. Immediately, upon reaching the house, before going any further than the front door, I heard the labored, distressed breathing with the sound accompanying membranous croup.

The child was lying on the bed struggling and gasping for breath, the face pinched and drawn, nostrils working violently, lips pale, the neck and clavicular region contracting and relaxing in the violent and exceedingly strenuous efforts made to get relief.

Realizing the imminent danger of the child, I at once sent my carriage for Dr. J. A. Perkins.

After he had examined the patient, we both concluded that tracheotomy was not only indicated but imperatively demanded, the exigencies of the case precluding the possibility of relief through others than mechanical means, still to give the child both the opportunity to return home as well as to make assurance of the necessity doubly sure, we decided to wait to four o'clock, at which time we plainly and fairly placed the case before the parents and friends, explaining the danger as well as the possibility of relief to be given through opening the larynx.

The child was then turned over to us to do as we thought best.

Having made such preparation as were necessary, we began the operation at five

o'clock, two ladies kindly holding the extremities and Dr. Perkins managing the head (no anaesthetic was used, though I now believe chloroform would have been proper, and would have helped to overcome the spasm which is always present).

The superficial vessels were avoided, and by going slowly, the deeper seated ones as they came to view, The cartilage having been exposed, the knife held by the finger and thumb and about one-half inch from the point was passed through and three rings were cut from below upwards, when the rushing and whistling of air in its passage in and out was quite alarming to all present.

A pair of small dressing forceps were next passed and opened, the violent and distressing respiration at once ceased, the child became tolerably quiet until the effort was made to introduce the tube, when it struggled considerably.

Not having a tracheotomy tube, and not being able to get one nearer than Baltimore, I had cut about one and a quarter inches from the top of a No. 14 rubber catheter, and passed through it two strands of waxed thread.

By keeping the forceps well opened I was enabled to pass the tube without any great trouble, when it was secured by the thread passed behind the neck and tied.

The child soon became easy, and in a little while dropped to sleep with its chances for life somewhat improved, but yet sufficiently desperate was the case, to lead me to believe it would not live.

There was only a moderate amount of haemorrhage, which, of course, ceased upon the introduction of the tube. A small quantity of blood got into the wind-pipe while holding it open preparatory to putting in the tube.

The next twenty-four hours passed without any great change in the child other than the increased supply of oxygen. At intervals the tube was cleaned with a feather; at no time while under my charge was the tube taken out. The distress of the sufferer was even now terrible, and the vital powers showed to

what an extent they had drawn. The second night passed very like the first. During the whole forty-odd hours I spent with the patient after the operation, at no time did it breathe through the natural passages, nor was the tube so clotted as to interfere seriously with its usefulness. Whiskey and milk were administered at regular intervals, keeping it well stimulated and nourished.

At this time influence unfriendly to me was brought to bear, and upon my return to the child after a brief absence the Friday morning after the operation (Wednesday afternoon), I find myself displaced and the case in the hands of a homœopath. The child has at this time improved so as to be about the premises.

Society Reports.

MEDICAL AND SURGICAL SOCIETY OF BALTIMORE.

STATED MEETING HELD FEB. 27TH, 1890.

The 707th regular meeting of the Society was called to order, Dr. H. T. Rennolds in the chair.

Dr. R. W. Mansfield said he had a large number of cases of

MEASLES

in his practice lately. A number were adults. Many were complicated with pneumonia. He delivered a lady, and shortly afterwards both she and the infant had measles, from which they recovered. He thought he had seen more cases in the last few weeks than he had seen in all his previous practice.

Dr. David Streett said he had seen quite an epidemic of measles lately, but all were of a mild type. Had not a single case complicated with pneumonia, though there was more or less bronchitis in all of them.

Dr. Wm. H. Norris said they had

treated a large number of cases of measles at the dispensary in the past two weeks, all in children. The environment of dispensary cases are bad, and they had lost two cases with lobular pneumonia. Measles in the adult is rare. In 1862, he saw some 500 cases of black measles at Fortress Monroe. They were in tents in the open field, and all did well. The mortality was very small.

Dr. Streett said he thought the mortality in private practice in measles was greater than it should be, on account of bad nursing. Of late he has gotten rigid in nursing cases of measles. He puts the patients to bed and insists on their staying there, preserving, as near as possible, a uniform temperature, regulates the diet and insists on good hygiene. He gives acetate of ammonia to produce sweating, and if there be much cough, he gives opium. Some severe cases will die, because of the germs being present in larger quantity. There may be some reason why cases complicated with pneumonia should prove more fatal than those with bronchitis only. As pneumonia is an infectious disease and we can readily understand that if a patient's condition be vulnerable there will be more probability of their taking pneumonia. Some years ago there was an epidemic of measles at St. Mary's Industrial School. They had a good deal of trouble. There were five or six deaths in a few days. It caused comment, and they managed the epidemic by putting all the sick out in the tents.

Dr. Shertzer said he did not believe in the germ theory of disease, and asked why the nurses do not take the diseases of those they nurse?

Dr. Streett said clinicians have neglected this subject, but that many cases of measles or of other diseases do occur in the same family and in one house, tenant after tenant taking it. *Dr. Shertzer* has had a number of cases of the same disease in one house, that could not all be set down to coincidence. Animals have pneumonia. A member of a firm that dealt in animals was attacked

with pneumonia shortly after having handled an animal that had it, and it was supposed that he took it from the animal. There is no way of demonstrating this fact.

Dr. Shertzer mentioned the case of a boy who died of pneumonia, where examination of the sputa shortly before death and of the lung after death showed no pneumonococci.

Dr. Streett said they are found only in the first stages of the disease. The longer the disease the less the number of bacteria.

Dr. Wm H. Norris said he did not think *all* cases of pneumonia were due to the micro-organism. He knew of a healthy man, aged 22, who went fishing, one warm summer day, and he accidentally fell overboard. He had no change of clothing with him, and as the weather was warm, he continued his day's sport. He came home, took pneumonia and in a short time he died. Another case of a healthy man, who, one warm Sunday, sat in a draught in church. He took pneumonia, and in a short time he died. He (*Dr. Norris*), did not think that the pneumonia in either of these cases was due to bacteria. He rather thought that the patient had pneumonia first, and that the bacteria find a nidus there, and that is why they are found there.

Dr. F. C. Bressler said the question of bacteriology can only be decided by bacteriologists, who work in that field every day. The general practitioner is not in a position to condemn. Who shall say that the ray germs of actinomycosis, bacilli anthracis and bacilli tuberculosis do not produce these diseases? If these three are positive, then *Dr. Shertzer* is wrong. Bacteriologists (though some cases are in doubt, further investigations will be necessary to sustain this point), inject the germ of septicæmia and there will develop a septicæmia. Examine the blood of a patient with malaria, between the attacks, and find the changes of the plasmodium malariae. Examine urine; when first passed it is acid, in a little while it becomes alkaline, in a short time

it again becomes acid. What is the cause of these changes? It is bacteria. Just as civilization has changed man, so has climate and altered surroundings developed bacteria. As to the pneumonococcus being the cause of pneumonia, study the phenomena of the disease. Its typical development, an acute, febrile disease. Typical time, running the course in from 9 to 13 days. Typical location, usually the right side first affected. All points to infectiousness. Sternberg has demonstrated it by the slide, and we are justified in taking the position that pneumonia is infectious.

Dr. S. T. Earle reported

A CASE SHOWING THE TOXIC EFFECTS
OF COCAINE.

On January 12th, was called to see a man, at 65, who was suffering from haemorrhoids, caused by a prolonged debauch. The patient was in a somewhat depressed condition, and therefore the operation for their removal was proceeded with cautiously. The haemorrhoids were clamped and cocaine injected, preparatory to their removal by the thermo-cautery. About a quarter of a grain of cocaine was injected at a time, until three-quarters of a grain had been used, when the patient became suddenly depressed. Nitro-glycerine was injected and amyl-nitrite was administered by inhalation, and when he reacted whiskey was given *ad libitum*. It was nearly an hour before the patient was safe. The operation had to be finished without any more cocaine, regardless of the pain. This is the third case where cocaine has had a toxic effect. In the first case gr. v were used. In the second case gr. ii were used, and in the case just reported gr. $\frac{3}{4}$ was used. These cases are reported as a warning against the indiscriminate use of the drug. In answer to inquiries, Dr. Earle said there was no history of epilepsy or uræmia in any of these cases, as those cases previously reported as having convulsions had never had a convulsive seizure, either before or after their experience with cocaine hypodermically injected.

Dr. Wm. H. Norris said he had not used cocaine to any great extent and had not observed any bad effects following its use. But we know some individuals have an idiosyncrasy against other drugs and may not these cases have been cases of idiosyncrasy against cocaine? He thought there might be some inhibitory action in cocaine, and those men who use it daily should call the attention of the general practitioner to its toxic effects.

Dr. F. C. Bressler said when cocaine was first introduced, he used it in a case of laryngitis. The patient was a female and rather nervous. A four per cent. solution was used as a spray, immediately she became pale and nearly fell to the floor, she had a spasm of the larynx. He injected $\frac{1}{50}$ of a grain of atropia, which was the only thing he had at hand and was very much alarmed for a few moments.

Dr. David Street said spasm of the larynx might be induced by the sudden impart of almost any substance sprayed into the throat, especially if the throat be in an irritable condition. About five years ago he had his throat sprayed by a specialist with a solution of silver nitrate, which caused an attack of laryngeal spasm and he did not wish to undergo the same experience again.

Dr. F. C. Bressler then reported

A CASE OF MAMMARY ABSCESS IN AN INFANT, FOLLOWED BY PYÆMIA.

Dr. David Street said he had had but two cases of mammary abscess in the infant, one several years ago and one at present. In both cases the nurse had squeezed the breast. This is a very common habit among nurses, and if they are cautioned against it, they are likely to do it clandestinely. Neither of his cases developed pyæmia. What had the cut of the umbilical cord to do with it? This is a suggestive thought. He had seen some cases of death where there was a saious discharge from the cut end of the cord, but had never had the opportunity to make a post-mortem. He had

a case of pyæmia following varicella, where there were ten or twelve superficial abscesses. What is the cause of these abscesses? Wherever we have abscesses we have the micrococci. In the case just mentioned, where there were abrasions of the integument in the eruption of varicella, the germ might easily get a lodgement, but their presence is not so easily accounted for in mammary abscess.

Dr. R. W. Mansfield said he had had a few cases of mammary abscess in the infant, all brought about by the unskillful manipulation of the nurse. None of them had been fatal. He asked what was the family history in Dr. Bressler's case?

Dr. Bressler said the family history was good, both parents being healthy.

Dr. S. T. Earle said abscesses frequently occur in tissues, where the micro-organism is taken into the system. It is not necessary for them to be introduced from without. There need not necessarily be an abrasion of the integument.

J. WM. FUNCK, M. D., Sec'y,
1710 West Fayette Street.

THE PATHOLOGY OF HEBRA'S PRURIGO.

The pathological anatomy of that extraordinarily distressing affection of the skin known as the prurigo of Hebra is a subject on which there are considerable differences of opinion, and which can as yet be regarded only as obscure. For this reason some importance must be attached to a paper by Dr. Kromayer, in which he gives the results of his microscopical examinations of skin excised from four patients, one of whom was a girl aged 16, another a man aged 57, the third a boy of 13, and the fourth a boy aged 6. All these were typical cases. When sections were examined from hardened tissue the epidermis was found to be thickened, particularly in the horny layer with formation of small cysts in that layer or under it. Only twice had he

found cysts in the rete mucosum. These cysts Dr. Kromayer shows good reason for believing to be due to the results of an exudation. The papules, although some of them were in connection with hair follicles, were not necessarily associated with these structures. The author regards prurigo as having its cause essentially in vasomotor changes in the blood vessels by which the epidermis is nourished, and therefore has some analogy to urticaria. He summarises the results of his work in the following sentences; 1. Hardened pruriginous skin is not suited to elucidate the anatomical changes in the papules. 2. In hardened sections he found thickening of the epidermis, particularly of the horny layer, which in the majority of cases was associated with the formation of small cysts. 3. These changes are referable without doubt to exudation in the cutis. 4. Prurigo consists in a change in the most superficial layers of the cutis, and in exudation depending on these changes. 5. The conditions under which this exudation is found sometimes in the cutis alone, sometimes in the epidermis alone, or in both together, are yet obscure; and fresh investigations towards elucidating the point require to be made on fresh and not hardened tissue.—*British Medical Journal.*

Dr. Biermer has been appointed Dean of the Medical Faculty at Breslau; in lieu of Professor Fischer, who is in bad health.

It has been announced that all the sessions of the New York Academy of Medicine have adjourned until October, and that the next meeting of the Academy will be held on October 2nd, in the new building in West Forty-third Street, where the library is now open from 10 A. M. to 10 P. M.

The contest for the vacant seat in the Senate of the University of London will lie between Dr. J. S. Bristowe, F. R. S., and Sir Philip Magnus.

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BALTIMORE, JUNE 14, 1890.

Editorial.

THE MUTUAL RELATIONS OF
THE HEALTH DEPARTMENT
AND THE MEDICAL
PROFESSION.

Although the frequent agitation of important questions in a badly managed city often does no more than create an ill feeling among those interested, still, nothing should keep *honest* reformers from endeavoring to improve what they consider faulty. Some of the defects of the Health Department are by this time evident to not a few physicians of this city, and opinions have been clearly expressed in these columns.

In this issue Dr. J. D. Blake, not only a competent physician, but an experienced politician, shows both the good and the bad side of the Health Department, and dwells particularly on the Sanitary Officers or Sanitary Inspectors. He shows, also, how impossible it is for the Vaccine Physicians to do their whole duty as required by law, and how their responsibility rests on the Health Commissioner, and his in turn, on the Mayor.

The Health Commissioner, in a recent paper before the Clinical Society, announced, among other things, that he intended to enforce the health laws very strictly, and as he is a man sincere and honest, he probably meant it, but any one who has read the health laws as laid down in the City Code will feel doubtful if the present Health Commissioner, among the onerous duties of his office, has had him to consider carefully those laws to which he has, as a city officer, subscribed.

As far as can be ascertained, no changes of importance have been made in the Health Department since the new Health Commissioner went in, and it is a sad fact that the Health Commissioner has not the power to remove his subordinates, however humble be those positions, without the permission of that "invisible power" that manages Baltimore politics, and our efficient Health Commissioner as well.

The sanitary inspectors should not be ex-saloon keepers and ex-convicts, but physicians, as in other cities, for even New York, so much more politically corrupt than Baltimore, sees the importance of having young physicians of experience to do the inspecting, etc.

The amendment which Dr. Blake proposes in his article has many advantages over the present system, and in one other point he is very strong, and that is in his reference to the apathy and indifference of the medical profession toward the Health Department of the city.

Criticisms may be made by some for political advancement, but many are sincere in their wish to have a model Health Department, and even the Health Commissioner, if he could with impunity express his secret opinion of his own department and could manage it according to his life experience and extensive knowledge as a thorough sanitarian, without fear of losing his place, would severely criticize many points and make the changes so necessary to render our Health Department the model one of the world.

SKIN DISEASE FROM ABUSE OF SOAP AND WATER.

Excessive use of soap and water is not often the cause of disease of the skin. The happy hunting-ground of the dermatologist is in the dens of poverty and vice of great cities, among persons who either cannot afford the luxury of frequent bathing, or who suffer from hereditary hydrophobia. In a clean, thrifty city—like Baltimore—there is not enough skin disease to “go around” and the physician who confines his work to this department has, as a rule, to advertise for it. At the opposite extreme of the social scale however, there is to be found among the devotees of fashion and of the table, a small but well-paying field for work. The specialist here becomes the trusted friend of society belles and beaux, youthful and aged, and having once

earned a reputation as a “beautifier” extracts the golden coin, or checks for the same, with most pleasing regularity. (This at least is the impression received by the less fortunate Aesculapian).

In the *Journal of Cutaneous and Genito-Urinary Diseases*, May 1890, Dr. Ricketts (apparently one of the fortunate) describes a diseased condition of the skin which is produced, not by the disuse, but by the excessive use of soap and water. It affects certain individuals with thin skins who, from a desire to enhance their personal beauty, or from a mania for cleanliness, wash their faces many times each day with soap and water, perhaps adding a rough rubbing with coarse towels or a coating of cosmetics. The result is an excessive exfoliation of the cuticle, the sensitive papillæ being often laid bare and compelled to exude a protecting mask of serum. The disorder affects chiefly the skin of the cheek, brow, and eye-lids. In these places it is reddened and more or less scaly. Considerable burning results from exposure to hot or cold draughts of air, and for hours after a scrubbing there will be burning and itching and an unpleasant sensation. At times the pain may even prevent sleep.

The disease is sometimes mistaken for eczema, the fair patient not even suspecting that cleanliness can become a vice.

The remedy is simple. Drop soap and use olive oil. Not common sweet oil nor cotton-seed oil, but pure olive oil. If the patient is exposed very much to dirt, as in Cincinnati, the skin may be cleansed by inunction with olive oil, and wiping with soft linen or silk. If beautification is the object, water and cosmetics must be discarded, and olive oil with

a little carbolic acid must be used, with an after-sprinkling of rice powder.

Dr. Ricketts is to be thanked for ferreting out one cause of grief to the "old campaigner," and for showing how a person may be clean, and yet comfortable, even in Cincinnati.

Reviews, Books and Pamphlets.

A Text-Book on Diseases of the Eye. By HENRY D. NOYES, A. M., M. D., Professor of Ophthalmology and Otology in Bellevue Hospital Medical College; Executive Surgeon to the N. Y. Eye and Ear Infirmary; recently President of the American Ophthalmological Society, etc. Royal octavo, 733 pages richly illustrated chromo-lithographic plates and 236 engravings. Price bound in extra muslin, \$6.00; in sheep, \$7.00. New York: William Wood & Co.

There is much to praise and very little to criticise in Dr. Noyes' book. The author makes some statements with which one may not agree, but he backs up what he has to say upon the disputed points in ophthalmology in a way that shows he has given the subjects such careful study as to make his opinions valuable. The book is essentially for the specialist. It is a very large volume, almost too large for convenient handling, but it would be difficult to say what could be properly left out with a view to making it smaller. There are no useless reviews of exploded theories, and no tiresome enumeration of discarded remedies. The author bases his views principally upon his own clinical experience. What he has found most serviceable in diagnosis and treatment is given the first place, although the methods of others come in for a fair and sufficiently full description.

There are two parts to the book. The first part consists of ten chapters devoted to the anatomy and physiology of the eye, the examination of the eye, ophthal-

moscopes, glasses, errors of accommodation and refractive binocular vision and paralysis of the extrinsic muscles, strabismus, asthenopia. There are twenty-two chapters in Part II, treating of the diseases of the various parts of the eye, lachrymal apparatus and orbit, the use of artificial eyes and statistics of eye diseases. Throughout, the text is beautifully illustrated. There are a few points which we may more particularly notice. In commencing the discussion of errors of refraction (page 68). Dr. Noyes says; "we ordinarily assume that correct visual acuity precludes refractive errors. It does preclude myopia, but it does not preclude a certain degree of hypermetropia nor of astigmatism." In our opinion the recognition of the possible existence of astigmatism in spite of normal vision ($\frac{20}{20}$) is of the highest importance. Many, who admit this error may exist with normal vision, do not think it worth correcting. In his "Treatise on Astigmatism" (1887) Dr. Swann M. Bennett called this error "Normal Astigmatism." On pages 55 and 56 he says that in cases of $V\frac{20}{20}$ "the existence of any abnormal astigmatism can be excluded," and that when, with the correction of manifest hyperopia, Vis $\frac{6}{5} (\frac{20}{20})$ "we may be sure that astigmatism does not exist."

We have repeatedly had clinical evidence to the fact that this so-called "normal astigmatism" can produce headaches and other symptoms of asthenopia; moreover that these symptoms frequently persist in spite of the correction of manifest H., and disappear when the correction of the "normal" astigmatism is made. Dr. Noyes is wise in putting this compatibility of normal vision with astigmatism so prominently before his readers.

Issue is taken with those who think a mydriatic always necessary. The following seems to us to include all the conditions under which it would be necessary to paralyze the ciliary muscle: when there is severe pain, when contradictory results are obtained after patient trial, when subjective and objective methods give opposite findings, when one sees by

the ophthalmoscope that spasm of accommodation exist" (page 68). Examination without ciliary paralysis may not reveal the whole amount of a patient's ametropia, but by it we are usually able to relieve his asthenopia.

Dr. Noyes has not been successful with homatropine (p. 69). We are surprised at this. A clue to his lack of success with it is found on page 87. He says: "With milder subjective symptoms hydrobromate of homatropine, gr. i-viii, ad $\frac{1}{2}$ i, may be dropped in, every two hours, till relaxation occurs."

The investigations of Dr C. A. Oliver, of Philadelphia, as given in Juler's textbook, show that ciliary paralysis can be attained with homatropine only by frequent instillations at short intervals. When it is obtained, it lasts (*i. e., complete paralysis*), only an hour or so. Hence, *two hours* is too long an interval between applications. Our own plan is to have the patient use the drops every ten minutes, for one hour, and come to the office immediately on the expiration of this hour. The strength of the solution ordered is gr. i-3*i*. In the vast majority of cases, tests for the range of accommodation show this function to be in complete abeyance, and the uncertain and contradictory results which led to the use of the drug disappear. In ciliary spasm it often fails, but, aside from this class of cases, we think, when used in the way suggested, it does effective work. Dr. Noyes wisely objects to the numerous optometers on the market because they call out accommodation.

Retinoscopy and other objective methods of examination are insisted upon as being more reliable than *subjective* tests. The definition of subjective examination, on page 68, is incomplete: "by test-types and spectacles." On page 79 the test based upon Schreiner's experiment is called *subjective*, although test-types do not enter it at all. Generally, we think of those tests as subjective in which we rely upon the patient's statements, or, as Landolt puts it, when "the examined eye is the judge as to the distinctness of the retinal

image." By objective tests, conclusion is reached without consulting the patient. Landolt's definitions are much better: Subjective methods are by rays *entering* the eye, objective by rays *emerging from* the eye. Thomson's modification of Schreiner's method is given by Landolt as subjective. On page 68 Dr. Noyes calls it objective, although his subsequent description shows it is subjective. One finds in the sections devoted to the correction of the different forms of ametropia, what is safe and practical. The difficulties met in daily practice are put in a particularly clear way, and there are many useful suggestions.

No hard and fast rules are made about correcting so much of the total error found, but the reader is presented with *principles* which should guide him: the condition of the fundus, the strength of the ciliary and extrinsic muscles, the age and occupation of the patient, etc.

The chapter upon binocular vision contains an instructive account of the paralyses of the eye muscles, dividing them, etiologically, into nuclear, basal and orbital paralysis. Plates of different parts of the brain are introduced, and aid one in understanding the text.

When strabismus occurs with amblyopia: Dr. Noyes thinks the amblyopia usually precedes the squint, rejecting the theory of "amblyopia exanopia." The chief factor in determining whether or not a hyperopic eye shall squint is the power of abduction. When this is normal or unusually great the axes will remain parallel. The author thinks it not advisable to overrate for squint before the fifth or seventh year.

The chapter upon muscular asthenopia is particularly interesting, the more so because this subject is now undergoing considerable discussion. Briefly, Dr. Noyes thinks that it is the *relative* power of abduction, and abduction which determines the way in which the eye muscles will work, rather than the strength of either the *externus* or *internus* considered alone. Adduction less than 5° he

thinks is pathological, and calls for treatment; just what treatment to be determined by the degree of adduction, the patient's occupation, etc. He thinks insufficiency of the externi is frequently overlooked, and that it often causes asthenopia. Weak prisms, base out, give marked relief. While the standard of normal abduction and adduction must vary within wide limits, he thinks they should usually for comfort hold to each other the proportion of 6° to 36° or 42° for distance, or "adduction 40° to 45°, and abduction 7°, which is about 6 to 1 or 7 to 1, not permitting abduction to go below 6°. For near, say at 13°, adduction 40° and abduction 20° suffice for comfort." Dr. Noyes thinks that a lack of balance in the eye muscles is rather the effect than the cause of chorea; that while it cannot be doubted that the correction of muscular troubles has often alleviated epilepsy, the muscular difficulty was simply the "exciting cause or occasion," and that there was "behind it a deeper lesion of the general nervous system."

It would be a pleasure to go particularly into Part II. All the subjects are admirably discussed. The management of the sick room or hospital, the action of remedies in daily use, the use of cocaine and antiseptics, are fully presented.

So far as we can see, the book is up to date in every way.

Hospital Reports.

PRESBYTERIAN EYE, EAR AND THROAT CHARITY HOSPITAL. MONTHLY REPORT FOR MAY 1890.

BY JULIAN J. CHISOLM, M. D.,

Surgeon-in-chief of Hospital.

New cases admitted for the month of May 1890.	836
Number of attendance for month of May.	3,571

Average for each day at the Free Dispensary.	132
Number of operations for month of May,	125

AMONG THESE WERE;

Foreign Bodies removed from the Eye.	25
Senile Cataract Extractions.	10
Operation for Capsular Cataract.	1
Operation for Artificial Pupil.	7
Removal of Eye-Ball.	3
Internal Squint.	2
External Squint Advancement.	1
Cancer of Lid, Plastic Operation.	1
Plastic Operation for Lid from a Burn.	1
Ectropion.	2
Tarsal Tumors removed.	6
Pterygium.	2
Removal of Dermic Tumors.	3
Lachrymal Abscess.	2
Tear Drop, Canaliculus Section.	5
Abscess of Lower Lid.	1
Removal of Adenoid Growths from Pharynx.	19
Removal of enlarged Tonsils.	4
Removal of Epulis from Lower Jaw.	1
Cyst of External Ear.	1
Keloid from Ear.	1
Removal of Foreign Body from External Ear.	1
Paracentesis of Drum Head.	3
Ceruminous Impactions.	20
Opening Abscesses in External Ear.	2
Amputation of Deviated Nasal Septum.	1

Miscellany.

GLYCERITE OF CALF-PEPSIN.

Dr. Frank Woodbury (*Medical Bulletin, January, 1890*), draws the following conclusions as to the special advantages of glyceritum pepsini vitulini, or glycerite of calf-pepsin, as follows:

1. It is a peptonizing agent of considerable activity.

2. It has a special action upon the casein of milk. (Its strength should enable one fluidrachm to coagulate a quart of cows' milk in less than ten minutes). It is, therefore, especially suited to patients on a milk diet, and for infants with aepesia.

3. It is clean and free from offensive odor.

4. It is palatable.

5. It agrees with the stomach. In cases where cows' milk alone has been found to disagree, the addition of a little calf-pepsin has been found to entirely overcome the difficulty.

6. It is especially applicable to digestive disorders in infants.

7. It is less likely to communicate disease than any other kind of pepsin now employed.

8. It is manufactured as readily and nearly as cheaply as hog-pepsin.

9. It preserves its activity for a long time without deterioration.

10. It is the form of pepsin to prescribe for those persons who have religious scruples or prejudice against using anything obtained from the hog.

ANATOMICAL NOMENCLATURE.

The following is the preliminary report of the Committee on Anatomical Nomenclature of the Association of American Anatomists:

The Committee recommended:

1. That the adjectives "dorsal" and "ventral" be employed in place of "posterior" and "anterior" as commonly used in human anatomy, and in place of "upper" and "lower" as sometimes used in comparative anatomy.

2. That the cornua of the spinal cord and the spinal nerve roots be designated as "dorsal" and "ventral" rather than as "posterior" and "anterior."

3. That the costiferous vertebrae be called "thoracic" rather than "dorsal."

4. That the hippocampus minor be called "calcar;" the hippocampus major, "hippocampus;" the pons Varolii, "pons;" the insula Reilii, "insula;" pia mater and dura mater, respectively, "pia" and "dura."

The Committee desire frank and full expressions of opinion from scientific and medical journals, from individuals who receive copies, and from any others who are interested in the subject.

Professor Burt G. Wilder, Cornell University, Ithaca, is the Secretary.

—*Cincinnati Lancet-Clinic.*

SIR WILLIAM GULL.

The London *World* says:—The fact that the will of the late Sir William Gull has been proved, showing property to the amount of nearly three hundred and fifty thousand pounds, has created much talk during the past week. It is beyond a doubt that for the last few years, since physicians have doubled their fees, and since both branches of the profession are constantly in receipt of very large sums for expeditions by rail, the earnings of members of the healing art have very largely increased. There are possibly a dozen medical men in London who, at their death, will be found to have amassed a hundred thousand pounds; but there is probably not one who has put by anything like the fortune left by Sir William Gull. "Put by" is scarcely the term. Sir William was a very careful, not to say parsimonious, man, his expenses were comparatively small, he entertained very little, his practice was extensive, and from time to time he received from grateful patients, special presents of large amounts. But it was in the dealings with and the investing of those large amounts that the fortune was made, and in this it is understood that Sir William had the advantage of excellent advice.

By-the-bye, here is a good Gull story, which though a "chestnut" to some, to the thousands who have never heard it, is worth telling. Sir William's butler was a great character; a small, dark man always white-chokered, and dressed in black, with a calm solemn manner. His income from tips must have been large, as the waiting-room was always crammed, and the order of audience was settled by him. One day summoned to the street door by a more than ordinary fierce knock, he found an excited indi-

vidual just alighted from a cab. "Sir William Gull in?" "Yes sir." "I want to see him." "Have you an appointment, sir?" "Appointment?—no I'm very ill. I want to see Sir William." "Impossible, sir, without an appointment." Naughty word emitted by visitor; then: "When can I see him?" "Well, sir;" after consulting paper, "At eleven on Tuesday next." "Tuesday next be—! I'm very ill! I tell you I must see some one! Do you know any one near who could see me?" Servant, after cogitation: "Well sir," there's a gentleman over the way—a *very respectable practitioner named Jenner*—he might be able to see you.

—*The Canadian Practitioner.*

NOTHNAGEL'S PILL FOR CONSTIPATION.

B.	Podophyllin,	gr. $\frac{1}{10}$
	ext. aloes	gr. j
	ext. thei	gr. j
	ext. taraxacum, q. s.	

—*Medical News.*

Medical Items.

Dr. James M. Corkran and Miss Laura S. Emory were married at Centreville last Wednesday.

Dr. G. Y. Everhart, of Wetheredsville, Md., and Miss Grace Ehrman, of this city, were married last Wednesday.

The State Medical Society of West Virginia, has just closed a very profitable session at Wheeling.

Kemmler's last hope is gone, and he will soon be "electrocuted" in New York.

Dr. Frank Baker, of Washington, has been appointed curator of comparative anatomy in the National Museum.

Dr. Alex. S. Porter, of Lonaconing, Md., and Miss Ella Keen, of Perryman's, were married last Tuesday.

The 13th Annual Meeting of the Pennsylvania Pharmaceutical Society was held at York last Tuesday.

Dr. Christopher Johnston, Jr., has been reappointed Fellow in the Semitic Languages at the Johns Hopkins University.

The Medical Society of New Jersey held its 124th annual meeting at Schooley's Mountains. The work was varied by rambles in the country.

Dr. Wm. S. Halstead, of the Johns Hopkins Hospital, and Miss Caroline Hampson, of Columbia, S. C., were married on June 4th.

The New York County Medical Association has passed resolutions opposing the imposing of duty on foreign natural mineral water.

Dr. Gover Wickes, formerly of Baltimore, but now of Denver, Col., and Miss Jennie Whitmarsh, of this city, were married last Wednesday.

The ladies interested in the higher medical education of women at the Johns Hopkins University are said to have collected \$53,000 up to date.

Dr. Thomas B. Evans, of this city, has contributed a very important article on "The Responsibility of Dipsomaniacs" to the last number of the *Journal of the American Medical Association*.

The Pennsylvania State Medical Society held its 40th annual meeting at Pittsburgh this week. It brought back many recollections of the Johnstown flood, which prevented the meeting a year ago.

The Maryland State Board of Health

announces that it will prosecute any one detected in the adulteration of food or drink. Dishonest milk dealers should take warning. The move is an excellent one.

The Secretary of Agriculture, in stamping out pleuro-pneumonia on Long Island, is not meeting with that "hearty co-operation" from the farmers, so necessary to destroy this disease quickly.

Sir Morell Mackenzie is said to have been engaged by an American Manager to deliver a series of lectures in this country during the coming fall and winter. He is engaged for at least twenty lectures, at the rate of \$500 per lecture.

Dr. Charcot, the distinguished head of the Salp ti re Hospital, in Paris has just finished a long series of experiments in hypnotism, and pronounces, as his opinion, that only one person in a hundred thousand is subject to the influence.

Dr. O. W. Holmes says it is not true. The poet-physician has had it brought to his notice that a learned small girl of Boston has spoken of him as having been for many years a "Professor of Monotony at Harvard University."

It is estimated that man gets a complete set of brains every two months. If the average life of a nerve-cell is from two to three months, we would each get six new brains every year, providing that every cell is replaced in the same length of time.

Dr. Wm. Dicking, who was surgeon on the *Dacca*, which recently foundered in English waters, has been highly praised for his coolness when the ship struck, and his presence of mind, which undoubtedly resulted in the saving of many of the lives; thus fulfilling his mission to an extreme degree.

The French Government is, it is stated, encouraging French physicians to attend

the Berlin Medical Congress, and in order to give proof of its sincerity in this direction, four military surgeons of high standing have been ordered to represent the French army at the coming gathering of medical men.

Harvard is advocating a third year collegiate course. Professor Remsen, of the Johns Hopkins University, thinks three years long enough to finish the collegiate course preparatory to a study of this, one of the learned professions. More time can thus be given to special study.

Drs. H. P. C. Wilson and J. J. Chisolm sail next Wednesday for Europe. Dr. Wilson will attend the meeting of the British Medical Association at Birmingham, where he will be the guest of Dr. Thomas Savage, the President of the Section on Obstetrics and Gyn cology, and the colleague of Tait at the Woman's Hospital there. At Bristol he will be the guest of Dr. A. E. Austin Lawrence. Dr. Chisolm will visit the British Medical Association and the International Medical Congress at Berlin, at which latter place he will read a paper on the improved after-treatment of cataract operation as used at the Presbyterian Eye, Ear and Throat Charity Hospital, of this city. This paper is read at the request of several foreign physicians, who have begun to use the isinglass plaster. Both gentlemen will see the Passion Play at Ober-Ammergau.

The Royal Academy of Medicine of Cadiz offers a prize of 500 pesetas (\$100), with the title of Corresponding Member, to the author of the best essay on "Tuberculosis in its Relations to Surgery." The essays, which may be written in Spanish, Latin or French, must be sent to the Secretary of the Academy, Don Enrique Diaz Rocafull, before December 1, 1890.

A monument to the memory of Dr. Franz Anton Mesmer, from whom "mesmerism" derives its name, was unveiled at Dresden on May 26th.

MARYLAND MEDICAL JOURNAL,

VOL. XXIII. No. 8.

BALTIMORE, JUNE 21, 1890.

NO. 482

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Original Articles.

SIX CASES OF SCARLATINA, WITH A CASE OF SCARLATINA IN UTERO.*

BY H. S. HERMAN, M. D.,
OF STATE LINE, PA.

On December 12th, 1886, I was called to see Bessie K., aged 6 years. Her temperature was 102°, pulse 140. The child had vomited, and had anorexia, slight sore throat, no eruption, enlargement of the papillæ of the tongue, with characteristic strawberry appearance. The history was meagre; the diagnosis was scarlet fever. I immediately adopted precautionary means, and isolated the child and mother (who acted as nurse), but evidently too late, as the sequel will show.

The patient was given tincture of aconite root, spirit of Mindererus and chloride

of potash (having discarded the use of chlorate of potash for internal administration in infantile practice long since). I also ordered the child's body to be anointed thoroughly with carbolized vaseline.

On December 13th, the characteristic eruption appeared over the neck, breast and body, which soon extended over the face; the pulse was 120, temperature 102°. The treatment was continued with milk diet.

On December 14, the pulse was 112, temperature 100°. The case ran an uncomplicated course, the fever gradually subsided, the eruption faded away, with furfuraceous desquamation all over the body, with fingers, palms of hands and soles of feet last to peel off.

On December 20th, convalescence was apparently established.

CASE 2.—On the evening of December 21st, nine days after the first case, I was called to see Ella K., aged 7 years (a sister of case 1). Her pulse was 160, temperature 104.2°. She was delirious; had no eruption, no nausea, no anginose

*Read before the Washington County Medical Society, at Hagerstown, Md., April 9th, 1890.

symptoms. The child had appeared well up to that morning, as she had been playing with the other children. The diagnosis was scarlet fever, and the prognosis was unfavorable.

The treatment was with bromide of potash, 5 grains, and chloral hydrate, 2 grains, tincture of digitalis, 2 minims, with spirit of Mindererus and sweet spirit of nitre, of each ten drops, every two hours. There was apparent inability to pass urine, but no bladder distension.

On December 22nd, at 9 A. M., the temperature was 102° , pulse imperceptible, respiration irregular, nose and lips cyanotic, body covered with rash; instead of a bright, the spots were of a dark inky hue. Although considered a hopeless case from the first, I cautiously administered atropia and strychnia to stimulate the respiratory centers, if possible; besides digitalis, whiskey and milk in small quantities, frequently repeated, and as deglutition was difficult, the latter were given per rectum. At 10 A. M., the pulse was 180, respiration still embarrassed; comatosc condition. She died at 1 P. M., 24 hours from onset of attack.

CASE 3.—On December 22nd, 4 P. M., I saw Clide K., age 3. The pulse was 140, temperature 103.1° F. The strawberry tongue, sore throat, nausea and anorexia were all present. Diagnosis was scarlet fever.

Treatment was with chloride of potash, tincture of the chloride of iron, with tincture of aconite; the body was well anointed.

CASES 4 AND 5.—December 23rd, on making my morning rounds to see yesterday's case (No. 3), I was greeted with "Well, doctor, we have two more cases for you." Upon entering another room, there were two more "full blown" cases of scarlet fever, Alice K., aged 8, and Johnny K., aged 1, both covered with the rash, and concomitant symptoms, vomiting, anorexia, sore throat, itching, moderate fever and rapid pulse.

CASE 6.—Three days later, and fourteen days from the first case, December 26th, the last and remaining child, Harry

K., aged 5, was put to bed with the same disease.

The above cases all ran an even course, with some insignificant variations, except the 2nd case, which so speedily ended fatally (which probably was the means of saving the balance), and case No. 5 (Johnny K., aged 1), which was complicated with "purulent inflammation of the middle ear," with perforation of the drum, and ending in a disagreeable mastoid abscess behind the right ear. The purulent discharge from the right ear improved under disinfectants, such as listerine and iodoform, with instillations of a few drops of a ten grain solution of nitrate of silver into the external auditory meatus, sucked in by the inflation of the internal ear through the nares with a Politzer's air bag; the perforation healed up kindly and the discharge ceased in about two weeks, and the mastoid abscess was in due time cut open and also readily healed. There was no anasarca as a sequelæ in any of the cases; indeed, no nephritic complications, either acute or chronic, that caused any annoyance that was noted, unless it might have passed undetected in the second and fatal case.

During the weeks of anxious watching and nursing, the *mother* of these children was in constant attendance upon them, she being in the seventh month of pregnancy at the time the first child took sick.

CASE 7.—On the evening of January 2nd, 1887, I was summoned to see Mrs. K., who was suffering from nausea, slight elevation of temperature (101°), and uterine haemorrhage. As before stated, she was now about 7 months pregnant. The pains were slight, but haemorrhage was profuse. On examination, I found the external os uteri rather thick and spongy. I also found it difficult to insinuate the top of my index finger up into the canal, and could make out no presentation, not even so much as to find out if there might not be an overlying placenta causing the haemorrhage. I could detect no uterine contraction, but

all the time there was a flow of hot blood over my hand. It was a question in my mind as to the method of treatment. I plugged the vagina well with fine sponges steeped in boiling water and vinegar, put her upon $\frac{1}{8}$ grain granules of morphia, enjoined perfect quiet, and left, to call to see the whole family in the evening. In the meantime, I admonished the husband what might be expected at any time as regards the premature birth of the child.

I called to see the case in the evening. I now removed the tampons, gave a hot vaginal douche. Haemorrhage had now ceased, and as the woman was comparatively comfortable, save a slight elevation of temperature and a feeble and rather rapid pulse (90), I left some aconite and took my departure.

On January 3rd and 4th, she felt comfortable. I was now about to congratulate myself that she might be able to carry the child to full term.

On the afternoon of January 4th, a message was sent, stating I should come "immediately, that Mrs. K. was flooding and they thought she would die," being out when the message came, there was some delay before I reached the patient, about 4:30 P. M. In the meantime, Dr. Koons, of Ringgold, Md., returning from a visit to his parents in Pennsylvania, on his way home, was called in sometime after the message was sent to me, and the child was delivered as I entered the room. It appears the labor was short and natural, a few vigorous pains having terminated the labor, the placenta in a few minutes was removed and the uterus contracted well without any further haemorrhage.

The child, a male, was very small, ill-nourished, apparently dead, (as we expected it would be). As Dr. Koons had the kindness to give his attention to the mother, I attempted to resuscitate the child, which, by persevering in artificial respiration, hot baths and warm whiskey, friction, rubbing, etc., I was finally rewarded by a short gasp; my efforts were continued, when in about half an hour

respiration was fairly well established, (a surprise to all when fully resuscitated, thanks to Dr. Koons for his assistance in this emergency).

The mother made a rather tedious convalescence, fluctuating in fever and finally desquamation, and during this time I noticed the baby peeling off as all the others had done, or were doing. The desquamation kept on until it was complete, when only seven days old.

The report of the above cases having already probably, consumed too much time, I shall refrain from adding any remarks, leaving that to members of the society. But in conclusion I will state, that this child, after a very precarious existence, even after six months, during which time it seemed to be quite a curiosity in the community that it was still alive, and so very puny that at that age it weighed only six pounds, but now at the age of three years it bids fair to be the stoutest of the family.

Considerations:—

First, Could the mother have contracted scarlatina before labor, and afterwards have completed the attack, as desquamation also took place while in bed?

Second, Could the child have passed through part of the disease *in utero* and the disease run its course after birth the first three to seven days?

It would be interesting to devote some time to etiology, pathology, prophylaxis and treatment, if time would permit, especially in the light of advancing medical science of the present day, but as this may suffice to elicit expressions from members of this society (or others) I refrain from lengthening out this report on the therapeutics employed in the various cases, as I could contribute nothing new or original in that line, only to say that each case was treated upon its merits, and all finally made a good recovery after months of watching, except the fatal case (2).

The case of "purulent otorrhœa media" to-day has good hearing, the little boy now goes to school.

NOTE.—The above reports were taken

from notes but imperfectly recorded, as they were not intended, at the time, for publication or for a medical society, hence their imperfection and brevity.

V.—DISEASES OF THE PUERPERAL PERIOD. PYÆMIA. PERITONITIS.*

BY WM. S. GARDNER, M. D.,

Lecturer on *Obstetrics in the College of Physicians and Surgeons, Baltimore.*

Pyæmia is characterized by metastatic abscesses in different parts of the body. It is an infectious disease and has many points of resemblance to septicæmia, if indeed be not that disease. The micro-organisms present in both can not be distinguished from each other, and why they should develope and produce certain lesions under some circumstances, and at another time bring about quite a different state, is a point upon which our knowledge is deficient. To go over the etiology of pyæmia, would be to repeat that of septicæmia. According to Koch, the micrococci form small emboli which lodge in the capillary vessels and from the foci thus formed abscesses develope. The abscesses are found most frequently in the joints, lungs, spleen, kidney and liver, their frequency being about in the order in which they are mentioned. That the abscesses occur most frequently in the joints is probably due to the fineness of the capillaries and the firm, unyielding character of the tissues immediately around the joint.

CASE 966.—Labor was normal. On the second day she had a chill, the pulse rose to 132, and temperature to 105°. During the succeeding seven days the pulse ranged from 112 to 136, and the temperature from 99.5° to 105°. There were severe chills that came on at irregular periods. The temperature fluctuated greatly; the joints of the right elbow and both wrists became very much swollen,

painful, and red; there was profuse perspiration; there was some tenderness over the uterus, though there were no signs pointing to a general peritonitis. Tincture of the chloride of iron, with quinine given regularly, and an occasional dose of sodium salicylate to reduce temperature, were the only drugs used. The appetite was bad, and very little food other than milk and whiskey was administered. She died on the evening of the ninth day. No autopsy was allowed.

Pyæmia, as a rule, does not run nearly so rapid a course as it did in this case. It often assumes a chronic character. The following is a brief report of a case which I saw at the City Hospital.

Mary S., aged 27, white, married, was delivered February 10. 1887. She was attended at her home by one of the hospital students, a competent man who had been in practice some years. The room in which she was confined was a damp, dirty, ill lighted, badly ventilated basement. There was nothing unusual about the labor. She did well after labor until about the tenth day, when she became ill and was removed to the City Hospital. When admitted, her pulse was about normal, her temperature was only slightly elevated and she complained of little except general lassitude. Throughout her illness her pulse remained under 100, and her temperature while it was almost constantly above normal, never ran high. After being in the hospital a few days the left knee and the right wrist became somewhat painful, swollen and of a dark, dull red color. From time to time she had slight chills. She perspired at times very freely, her mind remained clear. She died November 21st, which was about one month after she was attacked. The post-mortem examination was made by Dr. N. G. Keirle. The following is an abstract from his record.

"Necropsy, 110, City Hospital.

* * * * *

Grating in right wrist and left knee-joints. Lungs normal, liver normal. Heart flabby, and right side contained a chicken-fat clot. The spleen was found

*Saturday Lecture at the College, April 26th, 1880.

to contain an abscess in its upper fourth, the walls of which were formed by the head of the pancreas, the diaphragm, and a coil of small intestine. The right kidney contained two minute abscesses. There were yellow foci in the cortex. The uterus was in a condition of subinvolution, and the os large enough to easily admit the finger. A larger amount of pus was found in the right wrist-joint, and in the left knee-joint. The cartilages of the joints were reddened, roughened, thickened and softened. Pus had escaped from the knee-joint and burrowed along the side of the thigh, following the muscle-sheaths."

Symptoms.—The symptoms may come on within forty-eight hours after confinement, but in the greater number of cases they do not occur until about a week after labor. The first distinctive symptom is a severe chill, followed by others at irregular intervals. These chills can be distinguished from chills due to malarial poison, by the latter returning at regular intervals of twenty-four or forty-eight hours, while the chills of pyæmia may come several times in one day, or there may be an intermission of two or three days. With each chill the temperature rises to 103.5° , or higher, temperatures of 105° being quite common. Profuse sweats, which are very exhausting to the patient, follow the chills. These are usually accompanied by a fall of temperature, sometimes to normal, though after the disease is fully established the temperature remains constantly somewhat above normal. Sometimes, shortly before death, there will be a gradual fall of the temperature. In a majority of these cases the pulse will be constantly above 108, and during the chill will rise to 120 or 140.

When the pus collections occur in a joint, its presence can usually be detected quite easily. At first there will be redness, swelling and pain in the joint, and later, fluctuation can often be detected.

The lungs are more frequently affected than the other internal organs. When the area affected is of very considerable

size, it will cause an increased rate of respiration, cough or often-pain. The finding of dullness on percussion, associated with crepitant rales, fixes the diagnosis. But in many cases the lesions in the lungs are small and give rise to no distinctive symptoms.

Should the abscesses occur in other internal organs, their exact location is very difficult to diagnose. The repeated chills and rapidly fluctuating temperature indicate abscesses, but their localization is usually not done until the patient is on the post-mortem table.

Prognosis.—Winckel states that the disease lasts, on an average, eighteen and one-half days.

Galabin says that in fourteen cases in which external pyæmic abscesses were formed, there was a mortality of 28.5 per cent: and that in twenty cases of secondary pneumonia pleurisy, the mortality was 70 per cent.

It is difficult to obtain statistics of the death-rate from pyæmia as distinguished from other septic puerperal processes, but the rate is probably about fifty per cent.

Treatment.—Just as in septicæmia, the most valuable treatment is prophylactic. After the disease is thoroughly established, the results of treatment are very unsatisfactory. If a pus cavity is discovered in one of the joints or at any place where its exact location can be made out, it should be freely opened, the cavity washed out with an antiseptic solution, and drainage established. This statement is the same as previously made in regard to purulent peritonitis. What has already been said of the administration of foods, tonics and antipyretics in septicæmia apply to pyæmia.

General and Pelvic Peritonitis.—I do not believe it correct to speak of local inflammatory processes, such as general peritonitis, pelvic peritonitis, cellulitis, etc., as other than lesions of septicæmia, yet there are certain cases in which the local disturbances are so prominent that from a clinical standpoint they deserve some especial attention.

Peritonitis.—CASE 1047. Primipara; labor normal. There was nothing unusual in the puerperal period until the tenth day, when she complained of some pain in the lower part of the abdomen, and some tenderness on pressure; the temperature rose to 100.5°. On the morning of the eleventh day the pulse was 124 and the temperature 103.5°; there were lancinating pains all through the abdomen, and great pain upon slight pressure. She was given opium for the pain, antipyrine to reduce the temperature, and cloths wrung out in hot water and changed very frequently were applied over the abdomen. The morning of the twelfth day the pulse was 128, temperature 103.5°, that evening, pulse 160, temperature 103.5°. She was given tincture of digitalis, gtt. xxx, and fifteen grains of antipyrine. At 10 P. M., the pulse was 120, temperature 99.5°.

By the seventeenth day the soreness and tenderness had disappeared and the temperature had returned to normal. She continued to do well until the evening of the twenty-second day, when the pain returned and the temperature began to rise. From the twenty-second to the fifty-fifth day her morning pulse ranged from 108 to 120, her evening pulse from 120 to 132; her morning temperature ranged from 99° to 100.5°, her evening temperature from 101.5° to 104°. For nineteen days out of thirty-three her evening temperature was above 102°. Antipyrine and quinine seemed to have little effect upon the evening rise; for instance, on the afternoon of the thirty-first day, thirty grains of antipyrine and twenty grains of quinine were given, and the evening temperature was 104°. The evening temperature of the sixtieth day was the first normal evening temperature after the relapse.

It may be added that she has since been delivered of a full term child, and passed through a perfectly normal puerperal period.

Symptoms.—Peritonitis is almost invariably ushered in with a chill and rapid rise of temperature; the pulse becomes

small, hard and rapid, varying in frequency from 120 to 160 per minute. Severe pains are felt all through the abdomen, which usually becomes exquisitely tender. This pain is increased by even the slightest movement or the pressure of the bed-clothes. The abdomen becomes much distended and tympanitic; the diaphragm is pushed up and interferes with the movements of the lungs. This mechanical displacement, together with the pain caused by the movements of the diaphragm, cause shallow and rapid respiration. Vomiting is a common symptom; it may continue until part of the contents of the small intestine is thrown up. Constipation is the rule, especially in the cases that occur in the latter part of the puerperal period, but in the cases of the earlier part of the puerperal period diarrhoea is common. The patient usually lies on her back with her feet drawn up, though in the case reported and in some others that I have seen, the legs were kept extended. While these are the common symptoms of peritonitis, it should be remembered that some cases will die of this disease in which the rise of temperature, great pain, tenderness, distension and vomiting have all been absent. I have seen the diagnosis in such cases confirmed post-mortem.

Treatment.—As was mentioned under “Septicæmia,” the treatment for peritonitis has had advocates that were much at variance with each other. The treatment by opium as taught by Alonzo Clark has been much used in this country and with apparently the best results. The point to be gained is the arrest of peristaltic movements, reduction of respiration, the maintenance of perfect quiet by the patient, and the supposed direct influence of the opium upon the process of inflammation. The amount of opium given is gauged by its effect upon the respiration. The quantity of the drug that will be borne by some patients is wonderful. Clark gave a patient 934 grains of opium in four days; Barker gave 13,969 drops of Magendie’s solution in

eleven days; Lusk gave over 1700 grains of opium in seven days; Dr. W. Page McIntosh, when resident physician at the Maternité, gave correspondingly large quantities, and the patient recovered. In one case, I gave a woman twenty-four grains of opium in about eight hours, with no other effect than to render her unmanageable, and afterwards succeeded in keeping her absolutely quiet and relieving all pain by giving one grain of opium with two grains of quinine every two hours.

Much relief is given the patient by the application of moist heat over the abdomen. I have in most cases for this purpose used a piece of flannel folded to several thicknesses and dipped into hot water. This requires frequent changes, but is light, clean, and gives good results. Turpentine stoves are also used, with undoubted advantage. Many abdominal surgeons now treat all their cases of peritonitis exclusively with magnesium sulphate. It is given in sufficient quantities to produce free evacuations of the bowels. All other medicines are withheld. If this method of treatment is successful after surgical operations, there is reason to suppose that it will be equally successful in peritonitis of the puerperal period.

What has already been said as to the administration of foods in septicæmia applies to peritonitis; but the giving of solid foods must be delayed several days after all pain has disappeared. In one case which I attended, the pain and tenderness had disappeared entirely; the patient was cheerful and had a good appetite, which the nurse very injudiciously gratified by giving her some turkey, with a small quantity of cranberry sauce. The result was a relapse of the peritonitis.

These patients must be kept in bed until all pain has disappeared and the temperature has returned permanently to the normal. It is only too frequent that relapses are caused by the patient leaving the bed too early, going to the water-closet across a cold floor in her bare feet, or some like indiscretion.

Pelvic Peritonitis.—CASE 994. White, primipara; labor normal. The first and second day the highest temperature was 100°. The third day she had a severe chill; the pulse rose to 140 and the temperature to 104.5°; there was pain in the pelvic region and tenderness upon pressure. Opium and antipyrine were given, and hot water applications made externally. The fourth day the morning pulse was 140, the temperature 102.5°. The same treatment was continued. The evening temperature was 98.5°, the pulse 104. The fifth, sixth, seventh, eighth and ninth days the temperature ranged from 100° to 102°. The pulse for the same period ranged from 80 to 120. The tenth day the temperature fell to 99°; the eleventh day it rose to 103°, and the twelfth, fell to normal. Subsequent to this, though the temperature chart was kept, I find that it has, unfortunately, not been recorded, but for several days after this I know that the temperature was not elevated sufficiently to be of any moment. Later, she had two or three very severe chills at irregular periods, with elevation of temperature, a return of pain in the pelvic region and tenderness on each side of the uterus. Each afternoon there was a rapid rise of temperature to 103° or 104°; at the same time the pulse would rise to 140 or 152. The morning temperature during this period was but slightly elevated. There was frequent and painful micturition, and ultimately quite a large quantity of pus was mixed with the urine. After this discharge of pus began she gained rapidly, and when she left the hospital she was in perfect health.

Symptoms:—While the pathologist makes distinctions between pelvic peritonitis and inflammation of the cellular tissues of the pelvis, it is extremely difficult for the clinician to do so, especially during the puerperal period, and there is really little to be gained by a differential diagnosis. These pelvic inflammations are usually ushered in with a chill and rapid rise of pulse and temperature, more or less pain, and tenderness

upon one, or sometimes both sides of the uterus. After a few days, by vaginal examination a swelling can be discovered on one or both sides of the uterus; sometimes the whole pelvis seems to be filled up, and the cervix scarcely to be found. The uterus becomes immovable and sometimes pushed to one side. Rarely, by extension, the effusion presses upon the nerves passing through the pelvis and affects the muscular action and sensation of the parts to which these nerves are distributed. Painful micturition, such as noted in the case reported, is not the rule. The rupture of the abscess subsequently into the bladder indicates its proximity to that organ, and also the probable cause of the pain on urination.

The fever is of the remittent type with evening exacerbations varying from 103° to 105° , and a corresponding increase in the pulse. The morning pulse and temperature will often be only slightly above normal. According to Winckel, suppuration takes place in about one case in seven. It is announced by irregular chills and a rise of temperature. If the pus is left to evacuate itself spontaneously, it most frequently does so just above Poupart's ligament, next in the order mentioned, into the colon, bladder, uterus or vagina. After the evacuation of the pus, as a rule the patient improves very rapidly.

Prognosis:—Pelvic peritonitis and cellulitis rarely terminate fatally. Shroeder found that the fever continued to the twenty-third day in thirty-five cases out of forty-seven. About three weeks is the average duration of the fever, and the convalescence is often protracted.

Treatment:—The patient should keep the recumbent position and perfectly quiet. Opium in some form should be given to relieve the pain. Hot, moist applications should be made over the lower part of the abdomen. After the acute stage has passed, vaginal injections of large volumes of hot water give great comfort to the patient, and seem to promote the absorption of the exudation. The bowels should be kept open with salines.

If there is suppuration, as soon as a point of fluctuation can be made out, an opening should be made, the abscess cavity washed out and drained.

Care should be taken that the bladder is emptied, because on account of the pain on micturition the urine is allowed sometimes to accumulate.

On account of the rather long course of the disease, special attention should be paid to the diet. Iron and the bitter tonics are of value in convalescence.

ODE TO AEscULAPIUS.

BY THOMAS H. BRAYSHAW, M. D.,
CLASS OF 1885.

Delivered before the Alumni Association of the
College of Physicians and Surgeons, Baltimore,
at the Annual Meeting, March 17, 1890.

The rhynmer, *pro tempor*,
My brethren, young and hoary,
Is the serving-man of fancy, in grave quest
Of a mystery deep, of a history pressed
On the leaves of the past; reaching back
to the hour
When AEsculapius, Father of Health and
Healing,
First knew the world. In time's lush floerw,
When the round earth was young, and feel-
ing
Fresh; Lo! here he dwelt. 'Twas Na-
ture's earliest day,
And full-orbed, he rose, this star of richest
ray.
The innocence of Eden scarce had van-
ished,
When (woeful Eve to barren desert
banished,
Where hidden horrors dread didst terrors
multiply),
Him pitying Heaven created at her an-
guished cry!
Born of the suff'ring, the longing woman's
soul;
Yea, begotten by the All-Merciful, that
suffering to control,
To Eve came AEsculapius, our fathersage,
A panacea bearing, her pangs to assuage.
The ingredients we know not, but I trow,

On similar occasions we use like simples now;
 For in the diary of that event, in train
 With exodus from Paradise, comes mention
 of young Cain.
 Ah! think of this, my brothers,
 Ere the selfish present smothers
 The kindly germ of sympathy,
 That makes the whole world kin to thee;
 Think of the infinite, fostering kindness
 That succoured the creature, whose moral
 blindness
 Lost us that boon—life immortal!
 Regain it we cannot without dissolution
 Of matter and mind. Locked is the
 portal
 Because of her sin, save by solution . . .
 Of Death's indescribable terrible mystery,
 And Life cannot fathom that awful history!
 For, foolish or wise, sinner or saint,
 Death is a verity the fancy cannot paint.

* * * * *

But Æsculapius won
 For Mother Eve, the vital race,
 That time, long gone,
 When Death and he fought face to face.
 Performing noble deeds—thus were his
 moments spent—
 Mercy and Healing were together blent;
 Ruthful, kind, wise, yet jocund natured, he
 Embodied all that's worthiest in humanity.
 And like a falling star, through æons
 unnumbered,
 Comes the story, sublime, of him, who
 ne'er slumbered
 When duty called. Hist! Let us heed-
 fully hearken,
 That 'reditary 'scutcheon we may not
 tarnish nor darken;
 For be we disciples of "systems exclusive"
 (A fantasy alluring as' tis delusive),
 Be we "pneumatists," "animists" or
 "vitalists,"
 "Brousaïsians," "archaists" or "humor-
 alists,"
 All shades of Allopathy that may be,
 And genuine each, as a month-old
 baby,
 Whate'er the *honest* fad that holds our
 brains in thrall,
 Æsculapius, god of Hygiene, is Father of
 them all!

And this in rhyming allegory,
 I've told the Sire of Physic's story.
 What does it teach? Endless endeavor
 From fallen man disease to sever,
 Reaches into the vast forever
 Beyond the black abysmal river.
 And, forgetful of earth and its transient
 glory,
 Makes life but a busy promontory,
 Where we set sail in the shades of even,
 And, freighted aright, gain the harbor,
 Heaven.
 Here, in this ancient hall doth softly
 linger
 Memories most fragrant, of each departed
 one,
 Who was wont to tell us, ere "death's
 effacing finger"
 Blotted out his form, of duties to be
 done.
 Thus, duty is our watchword, no matter
 how we pray,
 And our duty we must do, e'en if St.
 Peter gets the pay.
 Time hath upon his back, a yawning
 wallet ample
 To catch for oblivion, a bulky batch of
 alms;
 From each of us poor dogs, he has filched
 a weighty sample,
 And our ships of fortune fair, most hope-
 lessly becalms.
 Sirs: 'tis precedent we follow, we needs
 must be poor,
 Because the first M. D. owned but the
 clothes that he wore;
 And from the fashion-plates of that era
 extract
 A fig leaf, it seems served him for the
 thing we call *pants*,
 While his graceless son, the modern
 doctor,
 More gorgeously is garbed than reverend
 dean or proctor.
 In old world cathedral nave intoning,
 Or *avè* or *pater noster* droning.
 Sure Solomon in all his might arrayed,
 Wore not such toggery as to-day for man
 is made.
 Yet, as long as our glorious *alma mater*
 stands,

Gaining disciples from home and foreign lands,
 May her sons from wisdom's pap, drawing gracious virtues rare,
 Grow like the god in the niche over there.
 So lift up your voices, brothers,
 Shout it with a will:
 Here's to old AEsculapius,
 The Father of the Pill!

CLINICAL SOCIETY OF MARYLAND.

STATED MEETING, HELD MAR. 7TH, 1890.

The 230th meeting of the Clinical Society of Maryland was called to order by the President, Dr. Robert Morison, in the chair.

Dr. J. Edwin Michael reported

A SERIES OF CASES OF TRAUMATISM TO THE SKULL WHERE TREPHINING WAS DONE.

He did not present the report in full, but added two cases to six others that were presented to the Society last year. He related these two cases in detail and spoke of the good results obtained.

These two cases make a series of eight that have fallen into his hands. All of the cases had compound fractures, and three lost brain substance, and one of the number was fatal. He thinks it is valuable to compare these results with those obtained under the old method of treatment.

Dr. E. R. Walker said that he had had under his charge three cases where trephining was done. Two were done for traumatic epilepsy and the other for threatened insanity.

Dr. Wm. Osler asked if it was not possible, in traumatic cases, to disinfect the pieces of bone and replace them? He has seen cases in which so much adhesion took place after removal of bone as to cause serious symptoms.

Dr. Randolph Winslow said the practical point to be elicited from the class of cases under discussion is that we should not wait for the symptoms to come out, but should endeavor to remove a depressed bone at once. If this is done these subsequent symptoms will not arise. In reference to the implantation of bone, that operation has been done, and in some cases with success, but in others with very bad results.

Dr. L. McLane Tiffany spoke of epilepsy arising from injuries to the frontal region. He had operated on one such case about five months ago. So far, the patient is doing well, but it is too soon, of course, to speak of the ultimate results. Another patient, aged 28 years, was kicked in the frontal region by a horse, fourteen years ago. Ten years afterwards, convulsions came and marked depression of bone was found. This case was trephined and the depressed bone removed.

Dr. J. Edwin Michael said that he had purposely left out of his remarks the subject of trephining for epilepsy. In reference to the implantation of fractured bone, that question has been receiving a good deal of attention of late, and it will probably be a rule when the patient has received a simple fracture. Most cases, however, are compound in their nature, and the tissues are often in a bruised and mangled condition and mixed with dirt, etc. Under these circumstances, he hardly thinks the operation would offer encouraging results.

Dr. Wm. Osler read a most interesting and instructing paper on

THE EFFICIENT DOSAGE OF QUININE IN MALARIA.

He exhibited a number of charts showing how temperature was modified by small doses of the drug, and spoke of the different forms of malaria, the etiology of the disease, etc.

Dr. I. E. Atkinson said that the remarks of Dr. Osler and the cases he had related are very important in showing us

that small doses of quinine do good in this condition, but they do not prove that larger doses are not better. The doses of the drug usually employed have undoubtedly been larger than was probably required. As much as 30 grains have been given at one dose in cases of intermittent fever immediately preceding the paroxysm, but even that amount does not always prevent it from coming on. A probable reason that large doses are not efficacious as smaller ones frequently repeated, is, because all of it is not absorbed and passes out without doing any good. There is no doubt that calomel does good, clearing out the bowels in these conditions. The most satisfactory way to administer quinine is by the hypodermic method in the form of muriate of quinia and urea or the hydro-bromate. He has seen cases yield in two days from this method of treatment. He very frequently fails to cure cases of this affection if he gives less than 12 to 15 grains of the drug daily.

Dr. J. G. Wiltshire said: I have listened to Dr. Osler's remarks on the physiological action of quinine, with profit, and now I wish to speak of its antiperiodic action.

In the days of our fathers, and even in this generation when the physician was without the light that is now furnished him by the researches of our pathologists to guide him in determining the etiology of malarial fever, one need not wonder that quinine was given empirically. He did not know what he was combatting, though his treatment was rewarded with comparatively good results. Now that he does know what the etiological factor of the disease is, it would be inexcusable in one not to treat it successfully.

We are told by Laveran, Councilman and others that there are several varieties of the "bacillus malariæ," and that some if not all of them represent different stages of development, either by segmentation, or the growth of the whole body (of the germ). Since this is established we must accept the fact that the dose of quinine must be commensurate with the

stage of development of the germs; as they grow older, stronger, and more numerous, it must require a more heroic administration of the specific to destroy them. But just here appears a hitch in the study of the problem: the gradation in the development of the germs makes it an uncertain quantity. Apropos of this thought, a look into Dr. Councilman's study of this subject will reward one with the fact that the intra-corporeal variety of the organisms of malaria is so susceptible of the action of quinine as to yield its identity to 15 grains given *ter in die*, for two days. Upon other forms the effects were not so potent. The crescents were not removed from the field by large doses often and continuously repeated. Hence, in some instances, malarial fever is not answerable to the quinine treatment; it will not yield to our most energetic exhibition of the drug, but will to that of iron, arsenic, good food and open air exercise. These cases might be ascribable to the crescents described by Dr. Councilman, and certain meteorological conditions in the environments of the patients, the latter producing a diseased state of the blood, and this, in turn, furnishes a fruitful soil for the culture and growth of the germs. I think I am supported in this theory by Koch Pasteur, Ehrlich, Trault, and others, who say they "have never seen a bacteria in a healthy body." This would suggest that the disease habitat of the germs be looked after in the treatment of the malarial cachexia, as well as to the germs themselves.

Dr. James M. Craighill said we find in private practice that remittent fever is much harder to get under control than is the intermittent form of the disease. He related the case of an engineer who would have an attack of fever while in Baltimore, which would invariably leave him when he would go to the mountains.

Dr. A. K. Bond said we all know that we have in our midst a hospital that is equal to any in the world. Its mode of construction and management is ideal in its working. It is probable that malaria

treated in an institution of that kind, would get well without any treatment at all; in private practice things are different. The environments vary continuously, and for this reason hospital statistics do not always hold good. He would like to ask Dr. Osler to what extent he used aperients and what he used? He believes they are important elements in the treatment of the disease. He believes that we should cure our patients as rapidly as possible, and with as large doses as is required to accomplish that end.

Dr. W. H. Norris wanted to know how it was thought that the maladies morbi of malaria acted, whether through the blood or the nervous system, and how it was thought quinine acted?

Dr. E. R. Walker said he had practised medicine in South Carolina and other localities where malaria was prevalent, and he found that most cases were rapidly cured with a cholagogue and large doses of quinine. In the chronic forms it becomes necessary to build up the general health of the patient with tonics, good food, etc.

Dr. S. K. Merrick asked if any one present had noticed any modifications in malaria in the last twenty years; for it is now said that the congestive chill is rarely seen at the present time.

Dr. Wm. Osler said that he is sure the teaching of these charts show to-night, is "that without quinine the fever persists." If you take out of the medical literature of to-day the contributions of the hospital physicians, nothing else remains save perhaps, gynaecology. He cannot see that malaria differs in any locality. He usually begins treatment with a purge. In the persistent forms of malaria, quinine does not influence as readily as it does in the more acute forms, however, when the crescents are present in large numbers they do undoubtedly become diminished under its influence.

Dr. George H. Rohé reported

and showed the specimen. He gave a history of the patient, described the technique of the operation and spoke of the results obtained.

W. J. JONES, M. D.,
Recording Secretary.
1238 Greenmount Avenue.

THE ACTIVE PRINCIPLES OF JEQUIRITY.

A Dutch observer, Dr. Nicolai, has been engaged in a series of observations directed to the elucidation of the question whether the irritant action of the seeds of the Abrus precatorius, or jequirity, is due to a non-organized ferment or to bacteria. He found that while a pure culture from the seeds produced no irritation of the conjunctiva, a chemical preparation in which there were no bacteria set up the inflammation characteristic of jequirity. He concludes that the active body is an amorphous ferment or "entyme," which can be isolated in the form of a white powder. This substance caused conjunctivitis in four or five hours. Its activity was destroyed by a temperature of 180° C. when dry, but a 3 per cent. solution became inactive after being heated to 78° C. It was also rendered inactive by borax and by prolonged treatment with absolute alcohol. Chloroform, ether, and corrosive sublimate did not affect it. No resemblance could be traced between it and pepsin rennet or diastase. It appeared to have strong toxic properties, for when injected into the venous circulation in rabbits it rapidly proved fatal, causing convulsions and paralysis of the heart.—*Lancet*.

HEADACHES FROM TOBACCO OR ALCOHOL.

For headaches from tobacco or alcohol, the *Kansas City Med. Record* suggests the following:

B—Spirit. ammoniæ aromat., min. xxx
Spirit. chloroformi, min. x
Aquaæ, f $\frac{2}{3}$ j.—M.
To be taken at one dose.

MARYLAND MEDICAL JOURNAL

Weekly Journal of Medicine and Surgery,

WILLIAM B. CANFIELD, A.M., M.D., Editor

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BALTIMORE, JUNE 21, 1890.

Editorial.

RECURRENT HERPES ZOSTER.

Considering the frequency with which herpes zoster occurs, and the tendency of other forms of herpes to attack the same individual again and again, it is strange that the history of recurrent herpes zoster should be so recent and that so few cases should have been recorded. But sixteen years have elapsed since Kaposi published the first accurate records of a recurrent case.

In the *American Jour. Med. Sci.*, April, 1890, Dr. Hartzell gives an account of a case which occurred in his practice and reviews 11 other cases—all that he could discover in the literature of the affection. In the 12 cases the face was the seat of

disease in 3; the distribution of the brachial flexus in 5; of the lumbar plexus in 3; of the sciatic nerve and its branches in 1. In 2 cases the eruption was bilateral each time it occurred; in 2 others it was occasionally bilateral.

Kopp has described a case in which it occurred on the left side of the face seventeen times in five years, scarring the face like small-pox.

Various interesting complications have been observed. Von Dühring relates a case in which the recurring attacks of herpes zoster were frequently preceded by erysipelas or pseudo-erysipelas of the part. In this case the zoster of the femoral region, which occurred every six weeks, was occasionally replaced by an eruption of the foreskin, the intervals between the femoral attacks being much prolonged whenever a preputial attack occurred. Eliot had a patient who suffered from bilateral recurrent zoster of the side of the neck, associated with herpes of the penis; and Tilbury Fox had a patient who declared that the zoster recurred every summer, accompanied by herpes of the penis.

Kaposi published 3 cases in which the eruption presented some marked peculiarities. At the seat of the eruption the skin appeared as if cauterized by sulphuric acid or caustic potash, small eschars forming and leaving behind them scars of a keloid character. The eruption did not appear at once over the whole course of the affected nerve, as is generally the case, but its circinate groups—afterwards surrounded by other rings of lesions—appeared at first over the peripheral branches and extended up the nerve trunks toward the centres in successive outbreaks. In the first case reported by him there were 9 attacks at

intervals of from 3 weeks to 13 months.

In about one-third of the cases the exciting cause of the herpes was said to be an injury, though it is hard to see how, in some cases, there could be any relation between the injury and the disease. In 1 case it was ascribed to uterine disease, in 2 to injury to the skull or spine, in 1 to glycosuria, in 1 to severe abscess of a septic nature.

Recurrent herpes zoster differs from the ordinary herpes zoster not only in its recurrence, but also in its bilateral distribution, which suggest trophic changes connected with lesions of the nervous system centrally located.

Dr. Hartzell suggests, in conclusion, that many cases of labial and preputial cases of herpes, which occur again and again, are really examples of recurrent herpes zoster of very small nerve branches.

SOME UNUSUAL MODES OF INFECTION WITH SYPHILIS.

Dr. R. W. Taylor (*Journal of Cutaneous and Genito-Urinary Diseases*, June 1890,) reports some unusual way of acquiring syphilis, so that if a person congratulates himself on escaping that dreaded disease when exposed in the usual way, he will become thoroughly disheartened and in despair at the small chance of dodging the enemy, who may lurk in many unsuspected places. The unusual modes enumerated in this article are: by means of chewing-gum from one person to another, by unnatural practice, from post-mortem infection, from a caus-tie-holder, from a handkerchief, a bathing suit, a syringe, a pair of drawers, adhesive plaster, from a water closet, a conductor's whistle, a tongue scraper, a towel, a razor and the fingers. The

knowledge of such unusual modes of requiring syphilis should be carefully concealed from the laity, for if they should know too much, they would force their physicians to believe that syphilis may be acquired in every way except by connection.

Correspondence.

WORDS OF APPROVAL.

Darlington, Md., June 12th, 1890.

Editor Maryland Medical Journal:

DEAR SIR:—I write to express my thanks, and to say that you are entitled to the thanks of the profession at large for your very able, bold and manly defence of the rights and the dignity of the profession against political tricksters, such as appears to be the *Secretary of the State Board of Health*, Dr. C. W. Chancellor.

And, even if the *Governor* of the State allows himself to be “influenced” by medical or other politicians in ways inimical to the interests and to the rights of the *medical profession*, he at once becomes—as all officials in our free country—a proper object for such criticisms as contained in your most excellent editorial in the *JOURNAL* for May 31st, 1890.

Your independent course in this matter of the *meddling of medical politicians* with the rights of the profession will largely contribute to the respect due your *JOURNAL*, and, doubtless, will make substantial additions to your subscription list. You have my best wishes.

Very truly yours,

W. STUMP FORWOOD.

A new University “Poliklinik” of Orthopædic Surgery was opened at Berlin on May 22nd. Dr. Julius Wolff has been appointed chief surgeon to the institution.

Reviews, Books and Pamphlets.

Stories of a Country Doctor. By WILLIS P. KING, M. D., Member of the American Medical Association, Member and Ex-President of the Missouri State Medical Association, Assistant Chief-Surgeon of the Missouri Pacific Railway Co., Formerly Lecturer on Diseases of Women in the Medical Department of the Missouri State University, and Professor of Diseases of Women in the Medical Department, University of Kansas City, etc., etc. With illustrations by T. A. Fitzgerald. Kansas City, Mo., Hudson-Kimberly Publishing Company. 1890. Pp. 397. Price \$2.50

This is a rather interesting book in its way. It shows the hard life of the country doctor, and particularly the country doctor of the West. It is written in a style at times amusing, and at times rather startling in its experiences, but the writer evidently enjoyed his task and the readers will, in parts, enjoy the book. It shows a careful and close observation of human nature and the humor in some of the anecdotes is strongly suggestive of Mark Twain.

Ueber die historische Entwicklung der öffentlichen Gesundheitspflege. Rede gehalten zur Feier des Stiftungstages des Militärärztlichen Bildungsanstalten am 2nd August 1889. Von PROF., DR. AUG. HIRSCH. Berlin, 1889. Verlag von August Hirschwald. N. W. Unter den Linden 68.

This is a very lengthy and comprehensive address on public sanitation, which is principally interesting from its historical allusions.

Lymphatiques des Organes Génitaux de la Femme. Par le DR. PAUL POIRIER, Professeur Agrégé, Chef des Travaux Anatomiques, Chirurgien des Hôpitaux. Paris: Aux Bureaux du Prog-

rès Médical 14 Rue des Carmes. Pp. 60. Prix 2f (+0 cents).

In this brochure Dr. Poirier has recorded the results of 300 or more autopsies in which the lymphatics were injected and dissected out. It is a valuable work of reference for the scientific gynæcologist. The illustrations are very clear. The work is dedicated to Prof. Sappey, the celebrated French anatomist.

Revue Internationale de Bibliographie Médicale, Pharmaceutique et Vétérinaire. Dirigée par le Docteur JULES ROUVIER. Paris: Librairie Médicale Vve. Jacques Lechevalier, 23 Rue Racine. 10 Francs (\$2.00), a year.

This is a very praiseworthy and valuable work of the editor, Dr. Rouvier, and corresponds to the American "Index Medicus." It will appear quarterly, with the additional of a supplement, to appear about every month. The first number shows a careful culling from English and German, as well as French medical literature. It is a very inexpensive publication, and invaluable for public and private libraries.

Electrolysis in the Treatment of Stricture of the Rectum. By ROBERT NEWMAN, M. D., of New York. Reprint from *Journal American Medical Association*, May 17, 1890.

The Four Commencements —Valedictory Address to the Graduating Class ('90), at the University of Louisville. By J. M. BODINE, M. D., Professor of Anatomy and Dean of the Faculty.

Report on Medical Education, Medical Colleges, and the Regulation of the Practice of Medicine in the United States and Canada. 1765-1890. Illinois State Board of Health. By JOHN H. RAUCH, M. D., Secretary. Springfield, Ill.: H. W. Rokker, Printer and Binder, 1890.

J. B. Lippincott Company announce in press an important work on

Regional Anatomy in its Relation to Medicine and Surgery. By GEORGE McCLELLAN, M. D., Lecturer on Descriptive and Regional Anatomy at the Pennsylvania Academy of the Fine Arts, Member of the Association of American Anatomists, Academy of Natural Science, Academy of Surgery, College of Physicians, etc., of Pennsylvania. With about 100 full-page, fac-simile illustrations reproduced from photographs, taken by the author, of his own dissections, expressly designed and prepared for this work, and colored by him after nature.

To be complete in two volumes of 250 pages each, large quarto. The object of this work is to convey a practical knowledge of regional anatomy of the entire body. The text to embrace, besides a clear description of the part in systematic order, the most recent and reliable information regarding anatomy in its medical and surgical relations. The illustrations are intended to verify the text and to bring before the reader the parts under consideration in as realistic a manner as possible. Vol. I will be ready for publication about December 1st, and the second volume is expected to appear shortly thereafter. The work will be sold by subscription only, and salesmen will begin an active canvass the coming October.

The Annals of Gynaecology will hereafter be published in Philadelphia, instead of Boston, and be in charge of Dr. A. L. Hummel, of the University of Pennsylvania Press. Dr. Louis Starr will be associated with Dr. Cushing as editor.

PRESIDENT JORDAN, of the University of Indiana, will contribute to the July Popular Science Monthly a very readable article on *Evolution and the Distribution of Animals*, in which he shows what

bearing the fact of certain animals being found or not found in certain localities has on the origin species.

The ninth of DR. ANDREW D. WHITE's new chapters in the "Warfare of Science" will be published in *The Popular Science Monthly* for July. Its subject is *The Antiquity of Man and Prehistoric Archaeology*, and it tells how step by step "thunder-stones" or "heaven axes" came to be recognized as flint implements of human make, and how their discovery together with bones of men and of extinct animals in the drift established the very early appearance of man upon the earth.

The July *Popular Science Monthly* will contain an article by AUGUST WEISMANN on *The Musical Sense in Animals and Men*, in which he argues that, "as man possessed musical hearing-organs before he made music, those organs did not reach their present high development through practice in music."

An able and business-like article entitled *Concerning Corporation Law*, by AMOS G. WARNER, will appear in *The Popular Science Monthly* for July. It points out the main defects in the hotch-potch of laws regarding corporations in the United States, and gives four particulars in which our corporation law could be reformed so as to prevent frauds and secure greater responsibility.

Miscellany.

AMOEBAE IN DYSENTERY.

DR. W. OSLER, of Baltimore, contributes a note (*Centralblatt f. Bakteriologie*, vii, 23), confirmatory of the observations by Lösch, Koch and Kartulis on the presence of amoeboid organisms in the faeces and intestine of dysentery, Kartulis also finding them in an abscess of the liver associated with that disease. Dr. Osler says that so far as he knows, the presence

of these organisms has only been found in Russia and Egypt, which adds to the interest of his communication. The patient had lived in Panama for five years, when he suffered from chronic dysentery. In May, 1889, he travelled to Europe, spending several months in Vienna, when he had another attack of dysentery. He returned to Baltimore in December, and was seen by Drs. Osler and Friedenwald. For more than six weeks he suffered from irregular pyrexia, slight rigors, and sweating. On March 22nd Dr. Tiffany incised two abscesses in the right lobe of the liver. The bile-stained, creamy pus was found by Dr. Osler to contain amoeboid bodies, about twelve times the size of white corpuscles, and showing active movements. The protoplasm was composed of an external homogeneous portion and a central granular substance, in which were numerous vesicles of various size, and ill-defined nuclei. The amoebae remained active an hour after the pus had been evacuated; and in that which escaped afterwards abundance of these organisms were found, in one instance retaining their activity for more than six hours. The faeces, which had partly lost their dysenteric character, were found to contain similar actively moving amoebae. Dr. Osler says that the structure of these organisms, their movements and general appearance, leave no doubt as to their parasitic nature. He adds that his observations were confirmed by Professor Welch and Dr. Counsilman.—*Lancet*.

THE TREATMENT OF DYSENTERY IN CHILDREN.

Veillard recommends the following mixture in the dysentery of children:

R.—Powdered ipecacuanha . 25 grs.

Boil for five minutes in 3½ ounces of water. Filter and add:

Tinct. of opium, from 2 to 4 drops.

Cinnamon water . 3 drachms.

Syrup of orange flowers 6 “

—M.

Dose, for a three-year-old child, one dessertspoonful every hour, or at longer intervals if nausea is produced. To quiet tenesmus, enemata containing tincture of opium, or enemata of infusion of chamomile or of eucalyptus flowers, should be used.—*Annals of Gynaecology and Paediatrics*, May, 1890.—*Mel. News*.

STRYCHNINE BONBONS.

It is to be hoped that there is no foundation for the statement in American papers that the new sensation for American ladies is the use of strychnine lozenges as a pick-me-up. They are described as small doses of putty-colored grey, each containing one-thirtieth of a grain. At any rate it is exceedingly desirable that the allegation that these lozenges are to be regarded as a safe tonic, with a bracing effect after fatigue, should not be accepted by English men or woman as having a particle of truth. Strychnine is one of the most dangerous of poisons, and it has the peculiar property of being accumulative in effect. The thirtieth of a grain is a large medicinal dose, and in excess of the ordinary dose given under the most careful medical supervision, and any one who began the practice of using this most dangerous of poisons as a pick-me-up at all, would very soon find its ill-effects; and in anything like the dose mentioned these effects would probably lead to fatal accidents. The theatre and the sermon at church are described as places or occasions of *ennui*, in which the strychnine bonbons are particularly grateful. But any who adopt the system might easily become the subject of a sensational domestic drama, and their places in the church before long would only be as a passing prelude to doleful funeral service.—*British Medical Journal*.

VULVITIS FROM DIABETES MELLITUS.

—Professor Parvin presented to the class a case of *vulvitis* resulting from diabetes mellitus, and directed the following:—

Constitutional treatment for the diabetes and local treatment for the vulvitis, as follows:

R Atropin., gr. j
Aquaæ, f $\frac{1}{2}$ j. M.
To be used as a spray.

Also an ointment composed of sodium salicylate, benzoated zinc ointment, and tar ointment.—*College and Clinical Record.*

RESTRICTION OF HYPNOTIC PERFORMANCES.

We are very glad to see that a protest which we have repeatedly raised against the practice of hypnotism as a public entertainment is being pretty widely echoed by intelligent writers and thinkers throughout the country. The example of the regulations adopted in more than one Continental country might well be followed here. We can see no reason why the Home Secretary, armed as he is with powers for controlling public entertainments, should not forthwith prohibit hypnotic exhibitions as contrary to public policy, dangerous, and unedifying. Since the time when Mesmer, Braid, and Elliotson brought to notice in succession the subjective phenomena, of the meaning of which Braid alone appears to have possessed an approximately accurate appreciation, quacks and impostors have been quick to add imposture to empiricism, and to traffic in a practice which the most careful investigators in all countries have agreed to be one of very rare and irregular utility, and fraught with many dangers to the nervous equilibrium and psychological soundness of the subject. Hypnotism is apt to be a dangerous mental poison, and as such it needs to be fenced round with as many restrictions as the traffic in other kinds of poison. Narcotics of any kind are not to be handled by the ignorant, and are liable to reckless abuse by the feeble in mind or body.—*British Med. Journal.*

A NEW REMEDY FOR SEA SICKNESS.

Another remedy for sea-sickness is put forward by Mr. Charles W. Hamilton, Surgeon R. N. (*British Medical Journal*).

It is the seeds of the kola nut, of which half a drachm to a drachm are to be chewed slowly.—*Medical Record.*

TREATMENT OF PROFUSE MENSTRUATION.

The following prescription for cases of profuse menstruation is quoted by the *American Practitioner and News*:

R.—Dialyzed ergotin . . 10 drachms.
Glycerin 5 "
Salicylic acid . . . 30 grs.
Distilled water . . . 2½ ounces.

—M.

One teaspoonful diluted with three teaspoonsful of water to be injected into the rectum after stool once daily.—*Med. News.*

EFFECT OF THE EXISTENCE OF UTERINE FIBROIDS ON THE OVARIES.

Dr. Popoff, late *Chef de Clinique* under Prof. Lebedeff, of St. Petersburg, has published an account of a series of twenty cases of fibroma of the uterus, where the ovaries were removed and carefully examined. He found that they were invariably more or less diseased; the most general morbid condition being a hyperplasia of the connective tissue, with corresponding enlargement of the organ. The cortical portion was pretty equally affected; sometimes small yellowish spots being seen, sometimes the walls of the vessels being thickened so that their lumen was partially occluded and the nerves were atrophied. In some cases the follicles became dilated, a multilocular cystic form of degeneration resulting; in others they became obliterated altogether.—*Lancet.*

PREScription FOR MEN AFTER A DEBAUCH.

R	Spirit ammon. aromatic.,	f 3 ij
	Tinct. capsici,	f 3 j
	Spirit. lavand. comp.,	f 3 iv
	Soda mint,	f $\frac{1}{2}$ ij
	Tinct. opii camph.,	f 3 ss-j
	M.	

—*College and Clinical Record.*

A TONIC FORMULA.

Dr. Austin Flint, at the suggestion of Dr. Allaird Memminger, of Charleston, S. C., recommends the following tonic in anæmia from various causes. It has since been prepared by various wholesale druggists in the form of tablets and capsules, and one or two are given after each meal. The following is the formula:

Sodii chloridi (C. P.)	-	3 iij
Potassii chloridi (C. P.)	.	gr. ix
Potassii sulph. (C. P.)	.	gr. vj
Potassii carb. (Squibb)	.	gr. iij
Sodii carb. (C. P.)	.	gr. xxxvj
Magnes. carb.	.	gr. iij
Calc. phos. præcp	.	3 ss
Calc. Carb.	.	gr. iij
Ferri redacti (Merck)	.	gr. xxvij
Ferri. carb.	.	gr. iij

M. In capsules, No. 60.

Sig.—Two capsules three times daily, after eating.

PHYSIOLOGICAL ACTION OF FERRO-CYANIDE OF POTASSIUM.

The physiological effects of ferrocyanide of potassium not being fully known, Drs. Combemale and Dubiquet, of Lille, have made a series of observations upon dogs and guinea-pigs. They find that this substance may be administered in doses equivalent to two-thousandths of the animal's weight without producing serious toxic effects. In the dog it produces vomiting and intestinal disorders, but does not act as a diuretic; in the guinea-pig, on the other hand, which is one of the animals which do not vomit, even minute doses produce diuresis for three hours afterwards. The temperature, circulation, respiration and nervous system are not affected. The ferrocyanide is changed in the system into ferricyanide, and is eliminated as such in the urine.—*Lancet*.

FORMULÆ FOR THE ADMINISTRATION OF CONDURANGO.

Kraus, of Vienna, who uses condurango as a stomachic, gives it in the following combination:

B.—Extract of condurango	30 minims
Chloral	. . . 15 grains
Syrup of orange	. . 5 drachms
Distilled water	. . 4½ ounces.

—M.

Dose, from three to six tablespoonsful daily.

Or,

Condurango bark	. . 5 ounces
Hydrochloric acid	. . 15 minims
Elixir of orange	. . 2½ drachms
Syrup	. . . 5 ounces

—M.

One tablespoonful every two hours.—*Internationale klinische Rundschau*.—*Med. News*.

PERITONITIS IN TYPHOID FEVER.

Dr. Rennert reports three cases of typhoid fever with perforation of the bowel which recovered in the Friedrichshain Hospital in Berlin. In an interesting paper on the subject, he states that he finds that peritonitis may occur, even when there is no actual perforation, from the passage of pathogenic organisms through the partially destroyed walls of the ileum. As a rule, the peritonitis set up in this way is of a more circumscribed character than that which is caused by perforation; but, nevertheless, in some cases it is so extensive that it is impossible to avoid mistaking it for that due to perforation. For the purpose of prognosis it is of great importance to make out whether the flatus permeates the whole abdominal cavity, or whether it is confined within a limited area by the matting together of the coils of intestine. Dr. Rennert considers that the well-known sign of disappearance of the liver dulness is a strong proof in favor of the generalized affection; but if there be no change in the hepatic area, the prognosis is far more favorable. In this latter case it is quite possible for the patient to recover; but in the former the diffuse peritonitis which results invariably leads to a fatal termination.—*Lancet*.

PRESCRIPTION FOR THE EXPULSION
OF LUMBRICOID WORMS.

According to the *Annals of Gynaecology and Pediatriy*, the following is the Dujardin-Beaumetz's prescription for the treatment of lumbricoid worms:

R.—Tincture of kameela . 1½ drachms
Syrup of orange-peel ½ ounce
Water, sufficient to make 4 ounces

—M.

This should be taken in small doses at short intervals until all has been used. If the worms are not expelled within two hours after taking the last dose, castor oil should be administered.—*Med. News.*

ABUSE OF PURGATIVES.

Professor Sänger, at a meeting of a medical society at Leipzig, spoke very strongly on the abuse of purgatives. He complained that not only did the public buy immense quantities of aperient pills, draughts and waters, but that practitioners also pandered disgracefully to the craving for instantaneous relief from constipation, so common amongst patients. Quack laxative medicines were advertised in every newspaper, on walls, in stations, and on the trees and rocks in romantic districts of Europe frequented by tourists. The competition in invention of a new secret purgative was very keen. In this respect, a Polish doctor was not wise in his generation. This gentleman, who, according to Dr. Sänger, appeared to have no special anxiety about his patient's vermiiform appendages, prescribed gravel, and boasted that he had already prescribed whole cartloads; but a drug which anybody could scrape up in his garden could not be patented, and therefore would never gain the confidence of the public, who love mystery in purgatives as in other matters. Professor Sänger said that the abuse of these drugs caused, not habitual constipation, but rather "artificial constipation." The evil was most prevalent amongst women with chronic pelvic diseases, real or imaginary. He ordered, in such cases,

that all purgatives be discontinued. He never had bad results, even when constipation lasted for over a week. Belladonna was the only drug he ever used when flatulence, etc., set in, and when the constipation lasted for very long. He objected to dieting, which kept up a pernicious feeling of invalidism, and, finding that the patients drank little water, he made them take several glasses of filtered water daily, when fasting; occasionally whey or buttermilk was given as a change. Fruit, brown bread, and exercise were recommended. Professor Sänger found this treatment far better than massage, visits to watering places, enemata, and other familiar means to the same end. In the long run his patients had natural actions of the bowels, and were cured of their invalidism.—*Brit. Med. Jour.*

Medical Items.

Yellow fever reports are in order again.

Cholera is said to be very prevalent in Spain.

Dr. W. U. Miller, of York Pa., is dead.

The work of tearing down the old College of Physicians and Surgeons Hospital has already begun.

The daily papers announce the death of Dr. Theodore Michie of Charlottesville Va., in the 63rd year of his age.

Dr. J. T. Dawkins, of Port Republic Md., and President of the Calvert County Medical Association, was in the city this week.

A furnace will shortly be erected in the Central Cattle Market at Berlin for the burning of carcasses condemned as unfit for human food.

Dr. Friedrich Salzer, well known as having been Professor Billroth's chief assistant for many years, has been appointed Professor of Surgery at Utrecht.

Professor von Dittel, the distinguished Vienna surgeon, will celebrate the fiftieth anniversary of his graduation as doctor of medicine on June 9th.

Dr. Laveran, of the Val-de-Grâce Hospital, in Paris, has received a prize from the French Institute for his researches on the haematozoa of malaria.

Dr. W. H. Welch, of the Johns Hopkins University, sails for Europe next week to attend the International Medical Congress at Berlin.

Dr. Charles H. Wilkin, a prominent young surgeon of New York City, and a son-in-law of Mr. John Hurst, of this City, died of appendicitis recently.

It is proposed to found chairs at Naples and other Italian universities in seaport towns for the purpose of giving special instructions to medical men who take charge of ships.

Dr. W. P. Whitmore of Schellsburg Pa., and well known throughout Bedford County, died last week. He was a native of Virginia, and a graduate of the University of Maryland in 1880.

The Senate Committee on Forestry and Agriculture gave a favorable report on the necessity of having laws and penalties attached for the adulteration of food-stuffs, etc.

The 33rd Annual Commencement of Rock Hill College will be held at the Academy of Music, next Tuesday, January 24th, at 2.15 P. M. Interesting addresses may be expected.

The Sultan of Zanzibar has conferred on Surgeon Parke the Order of the Brilliant Star of Zanzibar, as a token of

his appreciation of the good services which he rendered in the recent Stanley Expedition.

A woman in Ireland who gave birth to a cripple child, has brought suit against a railroad company for injury in an accident, before the child was born, on the ground that the shock to her caused the child to be crippled.

Dr. H. H. Biedler will attend the International Medical Congress at Berlin as delegate from the American Medical Association. Dr. Biedler will also visit the large hospitals of the European capitals.

The Calvert County Medical Association was organized last January with Dr. J. T. Dawkins as president, Dr. W. F. Shemwell secretary. This association meets quarterly and the next meeting falls on July 2nd, next.

Dr. James Bosley and Miss Ruth V Waters were married last Wednesday; they will sail for Europe on Saturday, where Dr. Bosley will attend the International Congress at Berlin. Dr. J. Wm. Funck will attend to his patients during his absence.

By direction of the acting Secretary of War, Major George M. Sternberg, surgeon, will, in addition to his present duties, perform the duties of the post surgeon at Fort McHenry, Maryland, during the absence of that officer on leave.

At a recent conference of French lawyers, the following was discussed: "Has the Faculty of Medicine the right to make anatomical experiments on an executed criminal, in spite of the last wishes of the said criminal?" The question was decided in the negative.

The Free Lying-in Hospital of the University of Maryland, 622 West Lombard Street, is open for indigent women

expecting to be confined. Women are received two weeks before expected time of delivery, and kept until well enough to go out safely.

By a recent decree, everyone who wishes to practise dentistry and "phlebotomy" in Italy must henceforth have taken a legally recognized degree in medicine and surgery. Dentistry will, for the future, be taught in the surgical department of such medical faculties as possess the necessary equipment for the purpose.

A committee, consisting of Professors Moleschott, Corradi, Cocconi, Guareschi and Vitali, and Signori De Cesaris and Tacconis, Doctors of Pharmacy, which was charged some time ago with the revision of the Italian *Pharmacopæia*, has almost completed its task. The revision has occupied twelve years.

Drs. J. G. Van Marter Jr., and Arthur H. Mann Jr., of the class of 1890, University of Maryland, are in Rome. Dr. Van Marter has been working with Durante and Baccelli there. From there they both go to Milan to see Dr. Vallari. As Kocher, the celebrated Swiss Surgeon is dying, they will not go to Berne.

The advocates of higher education for women will read with joy the announcement that Miss Helen Leah Read of Boston, daughter of a physician of that city and a member of the graduating class in the Harvard Annex, has won the Sargent prize over sixteen male competitors. This prize is so difficult that it is rarely awarded in its entirety.

The Portuguese Government has ordered by a decree, dated March 13th, that saccharin, whether alone or mixed with any other product, shall be sold by chemists only on the prescription of a legally qualified medical man. Every contravention of this enactment, as well as the employment of saccharin in the

manufacture of sweetmeats and drinks, is made punishable by definite penalties.

The Medical Record says that the concluding work of the series Rougon-Maquart, by Emile Zola, is to be entitled "Docteur Pascal." The author is said to have taken for his hero and model the celebrated chemist and physiologist, Claude Bernard, whose domestic life, it appears, was so unhappy that he described himself as one of the "martyrs of marriage."

The following board of directors was appointed this week for the Northeastern dispensary, 1224 E. Monument street: Drs. C. C. Baldwin, Samuel F. Powell, George A. Hartman, D. C. Ireland, Wm. H. Fusselbaugh, James P. Frames, Chas. W. Hatter, James Belmont, Thomas L. Elliott, George B. Creamer, John H. Frames. Since January 1, 10,046 prescriptions have been dispensed by this dispensary.

Mr. Alonzo M. Hurlock, who for years past has made a specialty of collecting physicians' claims was admitted to the bar recently, and has removed to 17 St. Paul Street, Barnum's Building, rooms 21 and 22, where, in addition to his law practice, he will still continue to give attention to the collection business, for which, in his new offices, he has increased facilities.

The West Virginia State Medical Society closed its session last week with the election of the following officers: President, Dr. J. H. Brownfield, of Fairmount; Vice-presidents, first, Dr. D. Major, of Charleston; second, Dr. T. B. Camden, of Parkersburg; third, Dr. Lester Keller, of Birney; Secretary, Dr. J. L. Fullerton, Charleston; Treasurer, Dr. J. Campbell, of Wheeling; Board of Censors, Drs. Sharp, Schriver, Moss, Hall, Stifel, Wilson and Cooke. Place of next meeting, Fairmount. Delegates to the Medical and Chirurgical Faculty of Maryland, Drs. W. F. Van Kirk and G. E. Baker.

MARYLAND MEDICAL JOURNAL,

VOL. XXIII. NO. 9. BALTIMORE, JUNE 28, 1890.

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THE FUTURE OF OUR UNIVERSITY.*

BY EUGENE F. CORDELL, M. D.,
OF BALTIMORE.

I must confess to a feeling of self-distrust, Mr. President and Fellow Alumni, in undertaking the duty of being your orator for the evening, when I reflect upon the occasion which brings us together. As the successor of the eminent persons who have held the same honor on similar occasions, I cannot but feel my inadequacy to do justice to this august gathering. In the presence of many, much my juniors, especially of those who this day have entered upon the realities of a professional career, I might have ventured to hope at least to

say something interesting or profitable; but when I see about me the gray-haired veterans of the profession, and even members of the Faculty (some of whom were my own revered teachers in years alas, long flown), I recognize the difficulty of the rôle, which, not without reluctance I have undertaken to assume this evening. But if you will bear with my imperfections, I will endeavor to speak briefly upon a subject that I am sure will interest you all.

I take it for granted that my appointment to this duty was due chiefly, if not entirely, to my investigations into the history of our University during the last several years, and to the series of articles based thereon, which have from time to time been published. In acting upon this belief, I am at least sure that I am not disappointing you, whilst I am gratifying my own wishes. The University is a subject with which in some of its aspects, I am perhaps more familiar than any other that would be appropriate for

* The Annual Address delivered before the Alumni Association of the University of Maryland, April 16th, 1890.

this occasion. And what more acceptable one could be presented to such an audience as this? You are bound to her by ties close and tender; her honor is in large degree, your honor; the value of your degree depends upon her standing. Can you then ignore anything that concerns her welfare, particularly at this time when all eyes are turned upon her and all hearts are throbbing with admiration and delight at the noble endeavors she is about to make to place herself once more in the front rank of American Schools of Medicine?

In selecting some division of so large a subject, that might come within the scope of an anniversary address, I might have interested you most by describing some of the work in the past history of the school; for instance, her humble birth and the five years of her infancy as the College of Medicine of Maryland, her progress as a University under the Regents up to the first climax of 1825, the twelve years next succeeding of Trustees' sway, the period of the two schools and of the great law-suit, the recovery of control by the Regents in 1839, and the succeeding interval of reconstruction terminating in the innovations immediately succeeding the late war, or the gradual improvements and development of more recent years. I might have entertained you with an account of the duels, of the seizure of the University premises and the three days of martial law, of the lotteries, of the visit of General Lafayette, of the personal combat of two of the Faculty, of the amusing ceremonial attending the early commencements, of triumphs and failures, of self-sacrifice and devotion, of neglect and incompetency, of periods of revival and depression, or of other interesting episodes which I have rescued from the oblivion of the past. I might have excited your disgust or roused your ire by telling you of a library given up to dust and worms, and of a museum, purchased at an expense of thousands of dollars, once the pride and boast of the institution, long mouldy and neglected. Or, on the other hand, I

might have boasted that our University was one of the first to have its own hospital, and to institute clinical instruction as a regular part of its course,* to introduce the study of histology and modern specialties, and to recognize gynaecology as an important specialty; the second, as I believe, to *enforce* the study of practical anatomy, and that long before Harvard did so, it required two sessions for obtaining its degree. I might have spoken of illustrious fellow-alumni, who, in many parts of the world have reflected credit upon their Alma Mater—of Cabell, Dugas, Warner, Bartholow, Wales, Lee, Harrison, Wellford, Pallen, Glisan, Dowell, Yandell, Bishop Chatard, Kidder, Wood, Ephraim McDowell, and hosts of others, no less eminent. Dr. Clifford Allbutt has defined “a university” as “the collective soul of its dead and of its living teachers;”† therefore I might appropriately have dwelt upon the lives and services of those who have held the destinies of the University in their hands and who have imparted within these walls, ‡ instruction to us and our predecessors: learned Potter, the disciple of Rush, great in the lore of the last century, mighty with lancet and mercury but contemptuous of modern innovations; poetic and adventurous Shaw, who fell so early a victim to his scientific ardor; Cocke, our first anatomist, pupil of Sir Astley Cooper, who died the very hour he was to have delivered his introductory address in this very hall; the surgeon Gibson, fresh from Edinburgh, and of his seven years work here; the brilliant genius Godman, who lectured in the anatomical chair before receiving his degree and who left so distinguished a record as naturalist, anatomist, writer and lecturer, in the brief years which preceded his untimely death; the Scotch professor, Pattison, popular, pugnacious, full of

*It is a singular fact that the late Professor S. D. Gross claimed for Jefferson Medical College, that it was the first American school to institute clinical teaching; but Jefferson Medical College was not founded until 1825, whilst the Baltimore Infirmary was established in 1823.

†Lancet, October 5th, 1889.

‡The address was delivered in Chemical Hall.

energy and self-assertion; DeButts, the eloquent chemist; profound and philosophic Geddings from South Carolina; Turnbull, so skillful with scalpel; gifted young Wells, of Boston; Ducatel, the geologist; Dunglison, the prolific writer and lexicographer; the handsome Baker brothers, victims of drink; the classical Chew; Bartlett, the author of the great works on medical philosophy and fever; the famous and beloved clinician, Power; Roby, the eccentric, friend of Oliver Wendell Holmes; Charles Frick, who immortalized himself in both hemispheres by his original work on the chemistry of the blood, remittent fever and renal pathology; the erratic but talented college-founder, Warren, who has compassed three continents; Hammond, the well-known neurologist; the scholarly and amiable McSherry; and last though not least, him whom we called "emperor," whose noble figure so full of dignity and magnificent repose, as he stood before his class rod in hand, has been faithfully preserved in the life-sized photograph upon the green-room walls.

But, pleasant as it would be to dwell among the scenes of the past, our anxiety will allow us to think only of the great crisis which is impending in the immediate future. For the present, every consideration is overshadowed by this, and it becomes our duty to consider seriously what resources there are for meeting it. Of course it is already known to all here present that the authorities of the University have announced their decision to introduce various reforms in the conduct of the institution, commencing with the session of 1891. These reforms embrace a three-year course, a preliminary examination, a higher grade of requirements in candidates, a graded curriculum, and laboratory instruction. In taking this step the authorities have not claimed any credit, but state very frankly that they have simply endeavored to meet demands for better teaching, which they could no longer safely ignore or resist. Much has been said about

find it hard to approve of anything that is done at the University. It is said that the compulsory nature of the step deprives it of all merit, and they intimate that it is allied rather to the class of bad than of good deeds, so that, as before they lavished their criticisms and censure upon the Faculty or Regents for doing nothing, they now find fault with the method in which something is being attempted. It seems to me that it were much better for us to rejoice that so momentous a step has at last been taken, without stopping to consider the motives, no doubt various, of those who voted for it, for it is well known that the action of the Faculty was not unanimous. We may take it for granted that the majority acted for what they considered the best interests of the school, and if we were to analyze the motives of the authorities of other schools, as Harvard and the University of Pennsylvania, which have led the way in this reform movement, I presume we should find that they were of a similar nature. They simply saw that the demand would soon come, and they anticipated it and thus secured for their schools the benefits of the enhanced prestige and reputation which their action was sure to bring. In this there is undoubtedly something essentially selfish, although it is spoken of as disinterested action. If our Faculty was only forced into this step, why have not other Faculties felt compelled to do the same? Why, for instance, in the recent effort to secure an advance in this city, was the proposition declined, on the ground that it was not expedient or practicable for the schools of any State—meaning by this dubious phrase the schools of Baltimore—to take the step without a general action throughout the country? The opinion of two eminent teachers in the leading school represented was also very emphatic. While expressing their admiration for the action of the University authorities, they declared that in their opinion it was suicidal and would terminate the existence of the University. In justifying their own inaction, they also

declared that they did not see how the suicide of the Baltimore schools would advance the cause of medical education in America. The same opinion was held by one if not more of the University Faculty itself, for one of the professors declared to me that he thought the adoption of the proposed changes would reduce the number of the class to 50, and soon put a stop to further progress. My reply to him was that if duty and honor required that the change should be made, I, for my part, would rather see the University perish in the attempt than to have it survive, an opinion which I hope all present here share with me.

The difficulties in the way of adopting the new methods in the University must be very great to elicit such opposition and such opinions. It is not hard to understand why they exist. The whole trouble lies in the fact that *the University is an unendowed institution.* It is a self-evident proposition that the conduct of a first-class educational institution requires large outlay, and that this can only be satisfactorily met by an independent source of income. If one expresses such trite views in the presence of certain persons, he is considered to be indulging only in "chestnuts." But that they exist only in an abstract form in the minds of many, is evidenced by the fact that there has been no attempt to carry them into practical execution. I believe, Mr. President, that *the University is doomed if it does not very shortly secure an endowment from some source.* It cannot otherwise cope with the large expense which the next few years will impose upon it. I will quote the views of Professor Wm. H. Welch, of this city, upon this very subject. In an address delivered before Yale University, June 26th, 1888, he says: "A system of medical education in accordance with modern ideas and adapted to present demands cannot be maintained without endowment or State aid. More is required than didactic and clinical lectures and the simple appliances of former times. There is need of thoroughly equipped labora-

tories, which, if properly conducted, cannot be made self-supporting. In most of the German universities, nearly three times as much money is paid for the support of the laboratories required by the medical Faculty as is given in salaries to the medical professors. The medical school must be lifted above the necessity of obtaining its means of existence solely from the fees of students, if a higher standard of education is to be attained. *At present it would be suicidal for an unendowed medical school to adopt an ideal course of medical instruction.* Under present conditions such a school is likely to make its requirements no higher than is demanded by the students themselves." Now, I cannot for an instant suppose that the gentlemen who have composed our Faculties in past years can have held such a view, else they would have made some attempt to carry it into execution.

The next question is, how shall an endowment be secured? It is doubtless true that there would be greater difficulty in securing it now than in past years, when our University was the only school for medical education in the State. We could then have appealed to the pride of Marylanders, who, if the matter had been properly presented to them, might have been induced to aid a representative institution such as this. Now we can no longer assume such an attitude. There are other candidates for public favor whose opposition is to be counted on. Then there is the Johns Hopkins Hospital, with its enormous endowment and its projected medical school, to form part of the other great collegiate department. So that men of means might say, what need is there of another school when we are to have the model school of the New World in our midst? As it appears, therefore, a great opportunity has been lost, never, perhaps, to be regained. Still, let us not despair. There are wealthy members of the Faculty, one of whom has just retired from it full of years and honors, and another must, in the natural course of events, soon withdraw, who may

realize that they may make good use of some of their surplus money in this way. And here I would say that I think it is particularly incumbent upon members of the Faculty who can do so, to endow the institution, because, undoubtedly, they owe to it and to the position it has given them largely the reputation, success and practice they have had. Of course genius and talent will tell wherever they are placed, but at the same time a public position in a great school gives opportunities and incentives which may make an immense difference in one's career. As a matter of fact, I think we may rest assured that the careers of many of those who have achieved reputation and large incomes would have been comparatively obscure and unimportant without such aid. In justice to past Faculties, it must be said that few of their members have possessed means above their necessary expenses, and the vicissitudes of the school have much reduced the profits which they have derived from it.

Another resource is ourselves, the Alumni. An appeal might be made to wealthy alumni, asking bequests, etc. I am glad to be able to state that without any such artificial stimulus an alumnus in the far west has made a large bequest to the school, but it is, unfortunately, not immediately available.* Or a more general contribution might be obtained from alumni. Success would be more likely to be attained if some special object were designated towards which contributions were asked, as, for instance, a pathological laboratory. Laboratory work is suggested particularly because of its urgent need and because it is this department in which the heaviest expense will be incurred by the Faculty. A third plan is that of a direct appeal to wealthy individual citizens. That such an idea is not utopian (at least in other cities) may be inferred from the experience of a medical institution in a neighboring city. A few years ago the Faculty of this institution met to discuss the urgent need of more means to carry on their enlarged

work, and they decided to appoint a committee to call upon wealthy citizens for aid. This committee found one wealthy gentleman who was willing to give \$50,000, provided they could raise a like amount in the next six months. They succeeded in complying with this condition, and got their \$100,000, the interest of which, with that of additional funds, since raised, gives them an annual income of \$5,000 or \$6,000, amply sufficient to enable them to meet the expenses of first-class laboratories of all kinds. If, with the great influence which the Faculty of our University exercise in this city (and they have the cream of the practice here, as we all know), an appeal of a similar sort should be made, I can scarcely doubt that it would succeed. But there must be the *felt want* and the *zeal and energy* to supply it. Again, the members of the Faculty often, in their professional duties, come in contact with wealthy persons, who have the disposition of large funds. Many are bachelors or widowers, or have large fortunes. Often a suggestion to such persons would lead to a recollection in the will, of amounts, perhaps more, perhaps less. Bequests to hospitals and other institutions—not always strictly charitable—are constantly being made by the wealthy, and I see no reason why they should not be made to this institution or its hospital.

It has been alleged that the plan of organization of the University is an insuperable obstacle to its success and to its acquiring an endowment. It has been said that it is a private corporation, the property of several individuals, who are irresponsible, and who may dispose of it at their pleasure. That the corporation is a private one is unquestionable, ever since the decision of the Court of Appeals, in the suit of the Regents vs. Trustees, rendered in 1838. In 1825, on the basis of the University charter, and of certain lottery privileges afterwards granted, the State had taken possession of the University, abolishing the Board of Regents and transferring the control to a Board of Trustees, officers of the State. The suit was brought to test the legality of

*The value of this bequest is stated to be somewhere between \$10,000 and \$100,000.

this act. In rendering his decision, the Chief Justice declares that "the University has none of the characteristics of a public corporation," and the property "is its own, to be managed and disposed of by the *Regents* for the uses of the institution, in such a manner as they may judge to be most promotive of its interests," and further, that had any endowment been made to it by the State (which was not the case), that would not have altered its character. Most American schools have been founded upon this same plan. It is easy to say that it is defective, and that the institution should have been a State one. Possibly, although there are doubts.

The success of the University is very largely due to the personal interest and endeavor of those who founded and conducted it through its early years, and it might not have had these aids under other circumstances. In instances where institutions have been dependent upon State aid, this has not been supplied with any extraordinary generosity, nor have such institutions exhibited a very flourishing development. Take the Departments of Law and of Arts and Sciences of this University, during the period of State government above referred to. It was a capital objection to the government of the Regents in 1825, that the medical department had usurped all the prosperity of the institution—sucked all the blood out of the embryos, as it were. But the Trustees failed entirely on their part, to accomplish anything, and when they were forced to yield up the reins of authority, they left the law department (begun under the Regents) entirely defunct, and the department of arts and sciences with merely a nominal existence. It is useless to say the gentlemen composing the Board of Trustees were not the right men to manage the institution, for they included Roger B. Taney, Rev. Eddy Johnson, three of the Judges of the Supreme Court, and many more of the most eminent citizens of the day.

Still, as a *private corporation*, are there not defects in the organization of our

school? I think there is one great, though not insuperable one. The teaching body should always be distinct from the governing body, but here the former forms part of the latter, that is, of the Board of Regents, composed now, as you know, of the Faculties of the law and medical schools alone—there being no representatives surviving of the theological and literary departments.

Reasons readily suggest themselves why there should be an independent governing body. I will only adduce two that seem to me unanswerable: 1st, The teachers are thus relieved from the care and anxiety of financial questions (the great *bête noir* of our schools), and are able to devote themselves without distraction to their professorial duties; 2nd, The governors are removed beyond the reach of personal influence, and can act without prejudice and partiality for the good of all concerned. It must not be supposed, however, because the University is a private one, that there are no restraints, and that the property of the corporation is at the unlimited control of the corporators to sell or otherwise dispose of at their pleasure. It will have been seen that the will of the medical Faculty is limited by their colleagues of the law Faculty, and the records of the University show that not only have the latter exercised a wholesome restraint at times upon the former, but that they have given valuable advice and counsel upon matters where knowledge of law was of great service. Furthermore, the property of a corporation is not like that of an individual, but is protected by the terms of the charter, and can only be devoted to one specific purpose. A still further restraint is put in this case upon the Faculty of Medicine, for, as if to provide the utmost safeguard against an alienation of property, the Legislature of the State, in passing the act of restitution in 1839, required the Regents "to certify to the Treasurer of the State that the property and estate of the University should never be disposed of or converted to any other use than that of medical

science, or the arts and sciences generally, without the consent of the General Assembly of Maryland," and that in the event of a violation of this obligation, the General Assembly shall have power "to take possession of and control and direct the said property and estate for the purpose of promoting general science." Of course, against the possibilities of risks of mismanagement, we have no absolute security, but has any other institution? The gentlemen at the head of this school are more deeply interested in its welfare than we are, and we may, I think, fairly allow that they have an average capacity for managing business affairs of such magnitude. We may therefore conclude that when you, Mr. President, have reached such a hoary age (*longo intervallo absit*), that you begin to think about the disposition of your ample fortune, or when you gentlemen of the graduating class of 1890 shall each have acquired the fortune which lies waiting in the womb of the future for the skillful application of your Neale-Howard-Tarnier, or, perhaps—but in very exceptional cases—for a simple Sänger section—that we may then safely venture to advise you not to forget the dear mother who guided your infantile footsteps when you first essayed to walk in professional ways, who fed you from her ripe breasts with rich streams of knowledge, and when you were able to stand alone after the long months of toil, sent you forth with her blessing and her mark of approbation.

Now suppose that as faithful children of such a mother, the Faculty were to consult us as to what sort of an institution we would like our University to be, and I were asked to be your spokesman, what would be my reply? This:

That our University be satisfied with no second-rate position, but aspire to be the best among the best; not the twenty-fifth, or the fifth, or the fourth, but the first. It is well to aim high, and it is comforting to reflect that it is not always those who have most money at command who use it to the best advantage. Let particular stress be laid upon the founda-

tions of our training, the thorough mastering of anatomy, physiology, chemistry, histology and pathology. This department of the University has not been at all satisfactory in the past. Let us profit by the example of the University of Virginia, which, though but an obscure and almost purely theoretical school, has managed to send out men who always shine when brought into competition, and has thus established for itself a very enviable reputation. Let us establish at once the best laboratories and compel our students to spend the better part of two years in them. It is not a comfortable feeling for our graduates to note a sense of inferiority in their scientific training when brought in contact with other graduates. Let us teach our students in our own school, and not rely on the Johns Hopkins, or any other University to train them for us in biology, chemistry, and pathology. Let us establish our independence at once, and maintain it. Let us have thoroughly capable assistants specially trained in their several departments; let us treat them well, be as liberal in our supplies to them and in their income as we can, and then hold them strictly to their duties. Let us encourage merit and provide opportunities for those who evince ability and disposition for original investigation. Nothing conduces more to the reputation of an institution than first-class original research, prosecuted under its auspices and with its aid and encouragement. Let there be more work entrusted to subordinates, such as quizzing, etc. Let there be ample bed-side instruction for the third-year men, with divisions into small groups for training under the professors or their assistants. (I well recollect the profit and interest with which I followed the professors around the hospital my first year, enjoying many opportunities for personal examination of patients which I could not have had in the lecture room. And one case was of such interest that I was able to make my notes of it, including the post-mortem, the subject of my graduating thesis). Let the

Faculty adopt a broad and enlightened policy—one of conciliation not of estrangement and isolation, and free from selfishness and arrogance. Their great and arbitrary powers subject them to corresponding temptations, and to extraordinary responsibilities. Let them be ready to receive and listen to suggestions, sympathize with every movement which is calculated to promote professional interests or the health and well being of the community, and above all, strive to unite and vivify into active energy all the elements that may in any way advance the prosperity of the school.

And after we alumni, have been so liberal of our advice, must we contribute nothing else to the good cause? Yes, we must encourage and sympathize with every effort; we must defend the fair name of our Alma Mater when assailed; we must cease our carping and criticism; we must influence patients to enter the hospital and intending students to matriculate here; we must induce those who have means to dispose of, to contribute towards our endowment fund, and we must render similar substantial aid ourselves, when fortune blesses our labors. By these means we may hope to see this ancient and honorable school advance towards that ideal perfection which is the goal alike of all good men and good works, and we may render more and more real and sincere the aspiration which we have selected for our motto:

*"Filius sim dignus istud
digna parente!"*

LEPROSY, WITH REPORT OF A CASE.

BY ROBERT HOFFMAN, M. D.,
OF BALTIMORE.

(Continued from Vol. XXII, p. 491.)

February 10. No change. The lymphatic glands in both inguinal regions the

size of a saucer, are of considerable thickness and hardness. On repeated examination of the infiltrated portion of the skin, I find that sensation is slightly diminished compared to that of the healthy skin, the difference is, however, not considerable.

February 14. On the left elbow, there is a blister the size of a five cent piece, filled with serum; it was pricked to examine the contents. After staining with fuchsin, there were found formed beside destroyed cells, a number of faintly colored rods of irregular form and size, between the numerous blood-cells. After repeated examination of blood taken from the infiltrated portion of the skin, there was found, after staining with fuchsin, methylene and gentian blue in a watery solution, isolated rods in size and form corresponding to those of the lepra bacilli. The white blood cells are somewhat increased in number (four to seven in the microscopic field). The soft palate is dotted with several new superficial ulcerations.

February 15. New blisters have not appeared since the last examination. Patient takes 15 grains of salicylate of soda three times daily, and beside two sulphur baths weekly.

February 18. The skin appears cleaner, the crusts have nearly all fallen off, leaving the skin darkly pigmented. On removing one of the scabs on the right ring finger, pus was found to have accumulated. Newly formed superficial ulcerations are scattered over the soft palate and uvula. No change in the topography of the larynx. Patient complains of but little inconvenience.

February 22. Examination of the tough, slimy, purulent fluid from a blister of the left ring-finger, gives the following results: Thin layers of fluid which were placed on cover glasses, were dried over a spirit lamp, and then subjected to staining by various coloring fluids. Staining with watery solutions of gentian violet, methyl violet, and fuchsin, gives no satisfactory results; however, on putting the cover glass in an alcoholic fuchsin solution which was prepared accord-

ing to Ehrlich's direction, and removing them after remaining in it for six hours, treating with 30 per cent. nitric acid, and then passing the thus prepared specimen through an alcoholic solution of malachite green, a beautiful red staining of the bacilli was obtained, while the cell nuclei, and to a less degree the protoplasm of the white blood cells, took on a pale green color.

The bacilli are present in enormous numbers, they are seen partly in groups, partly single in the prepared specimen, the greater number, however, are in small groups in the body of the cells. The cells have nearly all the form and are the size of softened blood corpuscles some of them are larger, and others seem to be breaking down. Patient does not complain of feeling worse, but possibly is annoyed a little more by difficulty in breathing through his nostrils, and of soreness and dryness in his throat.

February 26. Patient's condition has not changed much. Subjective symptoms slight; laryngoscopic examination shows no change; destruction of the soft palate rapidly progressing, so that only one-third of the uvula remains, which has already been changed into a single knotty growth; on the left palatine arch a superficial ulcer is growing; perforating hole is seen at the base of this ulcer; at the inferior margin of the thickened portion of the posterior palatine arches, ulcers the size of apex have formed, of a whitish, lardy appearance. A piece the size of a flax seed was detached from the uvula, torn to pieces and stained according to Ehrlich's method. An enormous number of bacilli are seen, some between the network of fibres, in smaller number in the cells, all arranged in groups, and thus distinctly outlined from the green-colored tissue. One of the knotty growths of the left forearm was pricked with a needle, and blood taken for examination; however, after trying various methods of staining, it was not possible to demonstrate with certainty the presence of bacilli. An increase in the white blood-cells was found.

March 3. The ulcers of the soft

palate have not increased perceptibly, and those of the posterior palatine arches have already entirely healed; the scarred lines showing again much plainer. On the extensor surface of the right forearm several knots the size of a ten cent piece have appeared in the last week. Examination of sensation shows no material difference from that noted when patient was admitted. Ten different examinations of the blood were again made; however, no bacilli were found.

March 18. Patient was transferred on March 6th to the ward for skin diseases. On March 12th, he suffered from an attack of fever, preceded by rigors; complained of feeling exceedingly weak and sick; had three or four stools, of a diarrhoeal character. The following day had again an attack of diarrhoea, which weakened him so that he had to go to bed; this continued for three days, when the diarrhoea ceased; his general condition, however, did not improve; temperature between 101° and 102° . On the 15th, temperature dropped, and on the 16th and 17th it was normal; his condition seemed somewhat better. Patient could not attribute this attack of illness to any cause. The diarrhoea returning and the patient rapidly growing weaker, he was again transferred to the medical wards. Examination showed that patient had changed considerably; his face is thin and it seems that the knotty infiltration has been somewhat improved; the infiltration of the hands and calves has diminished very noticeably; so pronounced is this decrease that it cannot be alone attributed to the wasting of subcutaneous adipose tissue.

The sensation of those parts shows no change; ulceration of soft palate nearly healed, the uvula showing only a few tiny ulcers. Patient complains very much of the difficulty and discomfort suffered when breathing through his nose, he being obliged to sleep with open mouth. In the evening he has a rise in temperature, 101.5° , and a fuller pulse than normal.

March 23. A blebs, which formed during the last night on the fourth finger

of the left hand, was emptied of its bloody serous contents, and a microscopic examination made, which revealed a small number of bacilli, which were of the same shape and class as described in the foregoing lines. It would seem, therefore, from this, as well as from the decrease in the size of the knotty formation in the soft palate, as if the disease was at a stand-still. Injection of solution of nitrate of silver into the nostrils.

March 29. Patient has had fever for three days, and does not seem to be so well. The adipose tissue has diminished considerably; however, a decrease in the infiltration is quite marked. Liver and spleen enlarged; the lymphatic glands unchanged—possibly a little softer to the touch; patient growing thin rapidly; the mucous membrane of the mouth and eyelids very anaemic in appearance. Repeated examination of the blood reveals no bacilli; on the calf of the right leg a painless fluctuating swelling the size of a saucer has made an appearance. Examination of the larynx shows a slight increase in the infiltration of arytenoid cartilage and false vocal cords; the infiltrated portions are of strong yellowish hue; the hoarseness of the voice has increased.

April 3. On the extensor surfaces of the calf of the left leg, four superficial skin abscesses have formed, the size ranging from a ten cent to twenty-five cent piece, the contents of which consist of a thin fluid of a yellowish red color, which, under the microscope, is seen to be made up of pus cells, epithelium, red blood corpuscles, and a broken-down nucleated mass; very few bacilli are to be seen. The epithelial cells, after decolorizing with a 30 per cent. nitric acid acid, are stained a green, partly an intense red. All of the examinations show the various hues in transition from green, through violet, to red. The red-stained cells appear shriveled and folded, whereas the green-stained cells are round, turgescent, and show a distinct nucleus. The dried scales of the epidermis of the skin which are scraped off, undergo a similar

change or reaction when submitted to the staining process; however, when stained with fuchsin they cannot be completely decolorized.

In a section the size of a pin's head taken from an infiltrated portion of the uvula, the bacilli are present in the same countless masses as here before described. The diarrhoea still continues, at times taking on a dysenteric character. Patient is constantly growing thin, appetite indifferent, anaemia pronounced, and is confined to bed. The sensory disturbances in his lower limbs have increased, sensation in the arms and abdomen unchanged. The upper portion of the abdomen prominent, patient complains of a burning in his stomach.

April 20. Quinine in 10 and 15 grain doses given repeatedly for the regularly appearing increase in the evening temperature of the last two weeks, ranging from 100.5° to 103° , without any results however. Patient is so exhausted he cannot leave his bed. The ulcer on his left elbow has increased in size and forms a raised, glassy, shiny, discolored mass of granulation, smelling badly and discharging a watery pus in which there are, however, no bacilli.

April 27. The infiltration of the skin of the back has diminished; the pigmented portion are unchanged, sensibility is improved and seems only to be modified in the pigmented portions. The infiltration of the arms and calves has diminished, voice somewhat better, anaemia still pronounced, and the patient still very weak. Several lumpy, brownish, haemorrhoids at the anal orifice. Patient complains of not being able to retain the faeces; touch does not reveal infiltration of the lower bowel.

(*To be continued.*)

A report of the Osaka medical work of the Japan Mission of the American Board of Foreign Missions shows a total of 2,581 persons treated during 1889, upon whom 375 surgical operations were performed,

DYSMENORRHœA.*

BY THOS. A. ASHBY, M. D.,
OF BALTIMORE.

Dysmenorrhœa is pain limited to the period of menstruation, as distinguished from pelvic pain before or after the menstrual flow.

Is the usual classification correct? Should not dysmenorrhœa be limited to conditions of uterine and not of ovarian origin? Does ovarian dysmenorrhœa properly belong to the subject? For didactic teaching the classification may be accepted, in the main, as correct. Clinically considered, the cause of dysmenorrhœa is composite. The varieties run into each other. Mechanical dysmenorrhœa rarely exists, pure and simple, as far as my experience goes. Hyperæsthesia of the cervix and body is almost invariably present, catarrh almost constant. If we remove the mechanical obstruction, still the pain often continues.

The treatment of dysmenorrhœa must be considered from a number of different standpoints. No recovery without this fact is considered.

1. Remove the obstruction.
2. Cure the hyperæsthesia and the catarrh.
3. Correct displacements.
4. Improve the pelvic circulation.
5. Constitutional and mental treatment.

Dilatation has afforded more satisfaction than any other method.

Dilatation is accomplished by using either Sim's or Goodell's instrument increasing the size of the canal of the cervix to $\frac{1}{2}$ to $\frac{3}{4}$ of an inch. Goodell has gone to $1\frac{1}{4}$ and $1\frac{1}{2}$ inches, though the latter is dangerous. I have used electricity with good effect, to 25 milliampèremeters, gradually increasing the sound to the largest size. It certainly relaxes the circular fibres.

Many women will not submit to any

operation by dilators, either under chloroform or cocaine, and will allow the use of electricity. It is necessary to keep up the dilatation to cure the catarrhal symptoms and keep the canal open. You must keep the woman under operative observation for several months. Sterility is almost always associated with mechanical obstruction, due to constriction. Dilatation cures this form. I have had no experience with posterior section. The catarrh must be cured, and dilatation has a tendency to cure by securing better drainage and allowing better application.

Membranous Dysmenorrhœa.—Of this, my experience is limited. I have never seen a case of complete cast of the entire uterine cavity, but have seen partial casts. The few cases under my personal observation were associated with the catarrhal conditions of the endometrium. One was a woman, married six years, who was cured of sterility and dysmenorrhœa by the use of the positive pole and nitrate of silver. The causation of this condition is still undetermined; the ovarian influence is purely theoretical.

Congestive Dysmenorrhœa is not a distinct disease, but a mere associated condition, whose cause must lie in mechanical disturbance of the pelvic circulation, or in vaso-motor influences; an increase of normal determination of blood at the time of menstruation; general pelvic congestion or engorgement; interference of the depletory process of the uterus and continuation of the congestive stage. The mucous membrane of the cervix is involved, swells up, as in coryza, at times, and an obstructive dysmenorrhœa is induced. There is a general engorgement of the pelvic tissues.

Treatment.—Local, alterative and astringent applications, correction of displacement; non-stimulation of sexual functions, removal of abuses of the sexual act.

Ovarian or Neuralgic Dysmenorrhœa, two distinct affections, but considered as one. In the neuralgic form, the pain may not be localized in the ovaries, or

*Abstract of a Lecture delivered before the Baltimore Medical Association, April 28th, 1890.

even in the pelvis. The uterus or any of the pelvic tissues may be involved. It is a pure neuralgia, as much so as facial or supra-orbital neuralgia. It is found usually in chlorotic, anaemic and neurasthenic women. We have a diathesis, rather than a local cause to deal with. The treatment is chiefly palliative and tonic. Examination of the pelvic organs afterwards reveals no satisfactory conditions to account for the trouble.

Ovarian dysmenorrhœa is not properly classified. There is a local lesion that interferes with proper functioning—a damaged ovary or tube. Pain is a more or less constant symptom, intensified at the period of menstruation. The ovary is often displaced; more frequently chronically inflamed and usually tied down by adhesions. The tubes are often destroyed. The treatment is of two kinds: 1, Palliative, which is unsatisfactory, and, 2, operative. Laparotomy is the only justifiable and satisfactory remedy.

In women who can afford to remain invalids till the menopause, palliative treatment may be continued; otherwise it is best to remove the cause. In operating, we rob them of nothing of use, but only rid them of a useless or diseased ovary or tube, which can only be a source of pain and worry while left, often bringing on hysteria, melancholia, etc.

Society Reports.

BALTIMORE MEDICAL ASSOCIATION.

STATED MEETING HELD APRIL 28, 1890.

Dr. H. H. Biedler related a case of

RESECTION OF THE METACARPAL BONES,

exhibiting his patient, who had had an impacted fracture of the radius and ulna, an impacted fracture of the metacarpal bones of the left hand, and an extended contused wound of the scalp, received in

falling through a hatchway and alighting on head and hand. There was no extended erysipelatous inflammation of the scalp. It was impossible to reduce the bones of the hand, and later he resected the bone with the result shown.

Though there was no erysipelas of the scalp, yet it occurred under the bandage on the hand and was quite severe. The wound, seen above, was made to let out the pus which accumulated. The operation, as you see, was a success.

Dr. Randolph Winslow said erysipelas is from infection, and evidently the infection by micro-organisms.

If we can keep our wounds septic we will not have erysipelas. There is no more reason for it in scalp, than in other wounds, if we keep them aseptic. He has had many scalp wounds to treat, but has never had any trouble with them.

Dr. H. H. Biedler agrees to the fact that erysipelas is infectious, but at times no matter what precautions are taken, a cellulitis sets up. In illustration of it, a gentleman had a slight razor wound, which apparently healed up well. One night he turned over on it, and a violent cellulitis set up, notwithstanding that Dr. Johnson and himself dressed it carefully, aseptically. It affected the corner of the wound, yet it did not apparently begin in the wound, which was a mere razor nick on the wrist.

Dr. Thomas A. Ashby then read a paper on

DYSMENORRHœA.

(See page 181.)

Dr. B. B. Browne thinks it covers the whole field of gynaecology. He prefers to divide dysmenorrhœa into two classes: 1st, those not accompanied by any decided inflammatory lesion. We find such in cases of flexion or version, especially anteflexion or anteversion. This condition is often found in sterile women. In such cases, electricity often does good. In the treatment of these, dilatation only does good in the milder cases. In

cases of much flexion, dilatation will not cure, as it does not relieve the condition of dysmenorrhœa and sterility. In these cases, posterior section does good. At the same time he curettes and tampons the uterus. It is the quickest and most satisfactory method. If the parts are tender and inflamed, he first treats them. In cutting the circular fibres, you cause a certain involution, so to speak, and cause the womb to draw up. Replacing the uterus and dilating usually cures dysmenorrhœa from retro-flexion or retroversion. In anteflexion, he uses the negative pole in the cavity. When there is inflammation he uses the positive pole.

Dr. J. H. Branham said one of the common forms of dysmenorrhœa (congestive or inflammatory), arising from catching cold, is usually corrected at the next period, if treated properly during the interval.

In those cases, as seen often in young girls, where the ovaries have not gone on to change, moral treatment—removing the patient from conditions which inflames, usually suffices. In many cases, taken early, other remedies than laparotomy will suffice.

Dr. B. B. Browne said there is one class of cases—women who have been healthy up to marriage, in whom, five or six months after, dysmenorrhœa sets up and sterility follows. This is usually due to latent gonorrhœa in the husband.

Dr. J. D. Blake said that Dr. Ashby stated that the stricture is similar to stricture in the urethra. He can readily understand why the negative would produce absorption, but is not satisfied why one gynaecologist uses the positive and the other the negative pole. He finds a vast difference between them—the one attracting, the other repelling fluids.

Dr. Browne said he uses the negative pole to promote absorption.

Dr. Ashby said the positive pole relaxes the parts, but does not produce absorption. He can often easily pass the positive pole when the negative will not pass at all.

Dr. Randolph Winslow exhibited specimens of

SALPINGITIS,

recently removed from a patient, who presented the following history:

B. B., white, aged 24, has had one miscarriage about four years ago. About one year ago, had gonorrhœa, and shortly afterward contracted syphilis. Pelvic distress, a year or more in duration. In summer of 1889, was admitted to Bay View, suffering with metrorrhagia, for which she was curetted by Dr. Winslow, with marked relief. Was subject to severe neuralgia in the head, probably syphilitic in character. Menstruation still too frequent and profuse, lasting seven days, with severe pain in left ovarian region. Upon vaginal examination, an enlargement is made out in the right ovarian region, which seems about the size of a small hen's egg, and which is the right ovary. Left side more painful on pressure, but the left ovary is normal in size; tubes on both sides enlarged. Uterus enlarged and somewhat retroflexed. Diagnosis: Enlargement of right ovary, and salpingitis.

Treatment: Bowels moved daily with saline, daily bath and vaginal douche. Abdomen shaved and bichlorided, on the night before operation. April 17th, laparotomy at the Hospital of the Good Samaritan; incision two inches long; appendages brought up without much difficulty and tied and cut off; drainage-tube inserted and incision closed with silk sutures. Patient did well, never having a temperature above 100°. Both Fallopian tubes were enlarged, tortuous, distended and completely occluded. Sterility was already absolute, hence it would be nonsense to speak of unsexing such a case.

Dr. Winslow presented a series of similar cases upon which he had operated, all recovering.

Dr. Blake desired to know what effect on the patient's condition has removal of ovaries and tubes,

Dr. H. H. Browne exhibited several specimens of ovaries and tubes, with history of each.

1.—Single, white, aged 26, has had one child and aborted two years ago. History of gonorrhœa some months prior to pain. Leucorrhœa very profuse. Examination showed a tumor, which he removed. In taking it out, the sac burst. It is a cystic papilloma.

2.—Single, white, aged 24, suffered from severe pain for some time, but only began to swell during the last six weeks. Ascles neenmulated so fast that the tumor was probably malignant. Menstruated at 13. History of gonorrhœa. Uterus pushed down and fixed in the pelvis. Hard tumor on the left side. No albumen in the urine. He removed the tumor, which is probably a sarcoma, but he has not yet made microscopic examination.

Dr. Ashby thinks these cases teach that we are justified in operating the abdomen, even when not quite sure just what character of lesion we will find. Formerly patients were allowed to go on from year to year, suffering from so-called pelvic cellulitis. These women were always sterile. The perks, even if able to function partially, do not accomplish anything. If the tubes be patent, we may have a case of abdominal pregnancy.

He has only lost two cases, one of which was moribund when operated on, hectic, temperature 103°, and the abscess had opened. In both cases the fatal result was due to not operating soon enough.

Dr. Winslow said he had not had a death in the last five years. Of the cases which have come into his hands, most have the history of gonorrhœa, and many of miscarriages. He thinks those are the most frequent causes of the trouble.

In regard to sexual feeling after operation, he thinks that located in the head rather than in the ovary or testicle. If but one ovary is removed, it is not affected.

Dr. J. T. King wanted to know the effect on menstruation.

Dr. Winslow said that where both ovaries

are removed it ceases entirely, or continues for a time as a habit.

Dr. J. W. Chambers said most cases of papillomatous like Dr. Browne's return in less than a year, and when the sac bursts there soon returns a general peritoneal affection.

HENRY B. GWINN, M. D.,
Recording and Reporting Secretary,
724 N. Gilmore Street.

DEATH FROM TIGHT LACING.

Happily the practice of tight lacing, though still a fruitful source of illness, does not now occupy a foremost place among the recognised causes of death. The fact that it does occasionally stand in this position, however, should be noted by those foolish persons whose false taste and vanity have made them the suffering devotees of a custom so injurious. It should be remembered also that, whatever may be said of the more evident effects, the indirect consequences of this tightly girding the body cannot be exactly estimated. They cannot but be hurtful. The veriest novice in anatomy understands how by this process almost every important organ is subjected to cramping pressure, its functions interfered with, and its relations to other structures so altered as to render it, even if it were itself competent, a positive source of danger to them. Chief among the disorders thus induced are those which concern the circulation, and it is to the labouring incapacity of a heart thus imprisoned and impeded both as regards the outflow and return of blood that we must attribute such disastrous consequences as occurred a few days ago in a Berlin theatre. One of the actresses, who had taken part in an evening performance, and then seemed to be perfectly well, was found next morning dead in bed. Subsequent examination of the body showed that death was due to syncope, and this was attributed to tight lacing, which the deceased had practised in an extreme degree. As regards the persons immediately affected, the warning conveyed by this incident is obvious.

Lancet.

MARYLAND MEDICAL JOURNAL

Weekly Journal of Medicine and Surgery.

WILLIAM B. CANFIELD, A.M., M.D., Editor

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(THE ACUTE FORM.)**

Swellled head (Megalokapaly) is a brain disease of moderate frequency, characterized by peculiar delusions in regard to personal magnitude.

The pathology has not been exactly determined, no fatal cases having as yet occurred. Whether it is due to atrophy of brain tissue or to the development of fluids or gases in the brain-cells, has not been decided.

It is observed in two forms, the *acute* and the *chronic*, which are so distinct from each other, both in their nature and in their course, that they require separate consideration.

The acute form occurs most frequently in young men at their first engagement in

the native responsibilities of life and also in older persons as a prelude to the chronic form to be described in a future article. The true acute form which does not become chronic, exhibits somewhat the following history. A young man, a physician, perhaps, makes a trip to the great cities of Europe or some other foreign land, and there takes in new ideas with great avidity. His mental cerebrations become perverted in consequence of the unusual strain upon the receptive faculties, and upon his return home he exhibits a most peculiar state of the centres which govern receptivity, and also of the imaginative centres which lie near them. His mind is in a condition of intense exaltation as regards his own importance in the community. There seems to be nothing of value in science save those things which have been impressed upon his own senses abroad. His dress, his speech, his bearing, indicate that he lives in an imaginary foreign atmosphere. In his manners he shows a sort of lofty disdain for things usually considered worthy of respect about him. New ideas suggested to him by his present associates he despises to consider, forgetting that conditions and remedies differ in different parts of the world. Moreover, his sense of his own exalted abilities never leaves him, even when he is making the most remarkable failures in his efforts.

The pathology of this disease has already been referred to as very obscure. Fortunately, its duration, in cases truly belonging to this class of acute disease, is generally brief. After a few months, or perhaps even years, of residence at home, the unfortunate afflicted, especially if he goes hard to work, returns to health. Gradually the brain-cells strengthen on

removal from the over-stimulating atmosphere of foreign climes, and the receptive powers begin to show themselves again, while the imagination recovers its tone and the patient begins to take a little notice of the conditions which surround him and to relapse less and less into the imaginary world in which his thoughts seemed to move. If a physician, he becomes less lofty in his intercourse with his associates, and learns again, by painful experience, the old forgotten methods of treatment for the various ills which befall the inhabitants of the district in which he lives. If the quality of brain-cell is good and the residence abroad has not been too prolonged or too frequently repeated, he may even attain to that humble frame of mind which has been the characteristic of the great fathers of medicine.

As the disease is an acute one, and under favorable circumstances self-limited, and as its germ has not been isolated, *treatment* should be directed toward general bracing of the mind. The patient should be treated gently by his friends, as mildly insane. Time, fair criticism and the hard knocks of life bring about recovery.

REPORT OF THE SECOND HYDERABAD CHLOROFORM COMMISSION.

Drs. John G. McKendrick, Joseph Coats and David Newman, members of the British Medical Association Committee on Anæsthetics (*British Medical Journal*, January 14, 1890.) have reviewed the work of the Hyderabad Chloroform

Commission and while differing in some points, they agree on the following:

1. We are agreed that death from chloroform occurs by failure of respiration, and that this is probably the most frequent mode of death.

2. We are agreed that chloroform causes a gradual fall in the blood pressure as registered by kymographic tracings from the carotid artery. This is the normal effect of chloroform.

3. We are agreed that when chloroform is pushed this gradual fall may be so great as to become in itself "dangerous." This is admitted in Paragraph (8) of the Hyderabad Report, where they state that after an animal has been involuntarily holding its breath "the gasping respiration which succeeds then causes very rapid inhalation of chloroform, with immediate insensibility and a rapid fall of blood pressure, *which quickly becomes dangerous.*" (The italics are ours.)

4. In addition to this, which we may call the normal effect of chloroform on the heart and blood pressure, both of us observed peculiarly sudden and unexpected falls of pressure, with slowing of the heart. We are agreed that this phenomenon occurs, and the Hyderabad tracings show that it is frequent. We differ as to the cause of its occurrence, the Hyderabad Commission ascribing it to asphyxia, while we contend that neither in the time of its occurrence after holding the breath nor in its general characters does it correspond with the fall of pressure due to asphyxia. Whatever be the explanation, the occurrence is in itself sufficiently serious, and should not be minimised as forming one of the sources of danger in the administration of chloroform.

Correspondence.**THE MUTUAL RELATIONS OF
THE HEALTH DEPARTMENT
AND THE MEDICAL
PROFESSION.*****THE HEALTH COMMISSIONER'S
REPLY.**

Editor Maryland Medical Journal:

DEAR SIR:—The article of Dr. Blake and your editorial comment thereon in the MARYLAND MEDICAL JOURNAL for June 14th call for a few words of reply.

Dr. Blake's paper is a general diatribe against the city ordinances governing the Health Department. Inasmuch as the officials of the department do not have the making of the laws, but their execution, much of his criticism is, as our German friends would say, "aus der Luft gegriffen." Reasonable Americans might dignify it by calling it "poppycock."

Referring to certain specific charges of what may be termed "compulsory neglect of duty," I would say that the orders of the Health Department to the Vaccine Physicians are to devote their attention principally to those classes of the population among whom the danger would be greatest in the event of an outbreak of small-pox. Granting that this would not be complying with the letter of the law, which was enacted when the population of Baltimore was little over 200,000, it is not contrary to its spirit, and if the profession and the public would only sustain the efforts made by the Vaccine Physicians there would be little reason for complaint. I believe there is very little now on this score, Dr. Blake to the contrary notwithstanding.

Dr. Blake's principal objection to the Health Department appears to be, however, that I did not turn out all the Sanitary Inspectors and appoint physicians to their places. Whether Dr. Blake's animosity against the Inspectors and the Department in general was aroused be-

cause his recommendations of applicants for appointment were not heeded, I do not choose to inquire. His charges against the Inspectors, so far as they may be reduced to specifications, apply to conditions existing six or eight years ago, and no instance is cited where the officers exceeded their authority within the last year or two.

Dr. Blake waxes humorous over the "minor avocations of life," from which the personnel of the Sanitary corps is drawn. He seems to think this such an important thing that he uses italics to impress it upon the reader. Now, if it were worth while to defend these officers against the charge that their occupations before they became servants of the municipality were "minor" and not "major," as they perhaps should have been, I might say that Abraham Lincoln was a rail-splitter, Andrew Johnson a tailor, and James A. Garfield a canal-boatman, before they became Presidents of the United States. So much for Dr. Blake.

Your own comments are so little to the point that they would deserve no reply, were it not that others no better informed than yourself might think your inferences and insinuations justified.

I will limit myself to two of the points upon which you attack the Health Department. The first is that "no changes of importance have been made in the Health Department" since I went into office. Now, I presume you refer to the personnel of the Department. I confess your criticism upon my action in this particular rather surprises me. I had supposed that one of the essential principles of civil service reform was comprised in the retention of experienced and efficient officials in office. This I did, and thought I deserved approval instead of unfavorable criticism. I am sorry to find that I was mistaken, and that I ought to have dismissed all the old experienced officers and appointed new ones, who could only become equally efficient after prolonged training, and who might leave the Department in the lurch in an emergency such as an epidemic of cholera or small-pox.

Regarding the politics of the appointees in the Health Department, I am free to confess that they all, so far as I am aware, belong to the democratic party, and I may say, further, that until the supply of good material in that party runs out, I intend that that complexion shall be maintained. Between an efficient republican and an inefficient democrat, I should choose the former, but other things being equal, the democrat will have the better chance with me every time. While upon this subject I may also say that the "invisible power that manages Baltimore politics" so far as appointments in the Health Department are concerned, is the record of the service of the appointees on file in this office. This record is open to the inspection of yourself or any other citizen at any time when public business would not be interfered with.

You say in the last paragraph on page 141, (MARYLAND MEDICAL JOURNAL, June 14): "The Sanitary Inspectors should not be ex-saloon keepers and ex-convicts, etc." Now, whether they are ex-saloon keepers is neither your affair or mine, provided they are efficient in the discharge of their duties. Personally I do not know whether any of them have or have not been saloon keepers. Neither I think, do you know that such is the fact. When you charge, inferentially and not positively, that any of the appointees in the Health Department are ex-convicts, you owe me and the public the specific proof.

I have always refused to entertain any general charges against the character of any of the officers or employees of the Department. So soon as a specific charge is made against any of my subordinates by name, I shall proceed to investigate it, and if the offense is of sufficient gravity and the charge is proven, there will be a vacancy in the Departmental force, or else a chance for some one else to become Health Commissioner.

Very truly yours,
GEORGE H. ROHÉ,
Commissioner of Health.
Baltimore, June 19, 1890.

Reviews, Books and Pamphlets.

Cyclopaedia of the Diseases of Children, Medical and Surgical. The Articles written especially for the Work by American, British, and Canadian Authors. Edited by JOHN M. KEATING, M. D. Vol. III. Illustrated. Philadelphia: J. B. Lippincott Co., 1890. Pp. xv-1371. Price \$5.00.

This volume has appeared at a very opportune time, coming as it does when the diseases of the digestive system are becoming very common. It contains 18 articles on this subject.

In looking at the articles in this volume (as in the previous ones,) it may be noticed that most of these may be divided into *practical*, that is, those written by men who have had an extensive experience, and give the results of their own observation with the best treatment; and *scientific*, that is, those by younger men, or those with limited experience in everything but the laboratory study of the disease. The combination of these two kinds of articles is an admirable plan, and this has been followed noticeably in these volumes, thus giving this book and the whole set a double value.

The articles of Drs. Pepper, Wilson, and Jacobi are particularly valuable for the practitioner. Dr. Holt's article is exceedingly comprehensive, and contains some excellent plates of intestinal lesions. Some of the articles seem to be rather superfluous, or are written by men not working sufficiently in that line. That on "Membranous Enteritis" by Dr. W. A. Edwards is written by a man whose literature and practice is devoted almost exclusively to pulmonary troubles. That also on "Parasites in the Intestinal Canal" by Dr. W. T. Councilman, is by a most experienced pathologist, but not a man who has probably had much practical experience with these diseases in children upon which he writes except in the autopsy-room, consequently his treatment is of little value. A few articles are so evidently written by men who have

had more access to encyclopædias than cases, that it seems a pity these few pages were not omitted or left to better hands.

The attempt to classify the intestinal bacteria at first seemed hopeless, but such specialists as Booker and Holt, whose articles appear in this volume, have done much in this direction and contribute articles well worth reading.

While it is hardly practicable to point out the good and bad points of each article by name, it is sufficient to refer to each general department. In Diseases of the Liver, Dr. Henry Dwight Chapin leads with a very valuable paper on Icterus and allied conditions, and is followed by Drs. Musser and Hatfield, who very thoroughly cover this usually neglected part of paediatrics. The diseases of the genito-urinary organs in children receive a wonderful amount of attention, nearly every little part being the subject of a monograph. Dr. J. P. Crozer Griffith treats the blood diseases in a masterly manner, and has some very well executed lithographs of abnormal blood conditions.

The surgical troubles have not been neglected. The various operations have been described and the article on minor surgery, of so much importance to the general practitioner, will be much appreciated.

Altogether, this volume while perhaps not up to the former ones, attains a very high standard, and the editor has evidently searched the two hemispheres for the best English writers.

The publishers deserve particular credit for the enterprise, they having paid very liberally for the articles, in fact, more than some were worth, and outlaid a large sum of money (probably long since returned with good interest). The special cuts and illustration are very liberal in number and good in design. This volume is also much larger than the preceding ones.

A Consideration of Three Successful Cæsarean Sections in Philadelphia. By HOWARD A. KELLY, M. D., Gynæcol-

ogist and Obstetrician to Johns Hopkins Hospital. Reprinted from the *American Journal of Obstetrics and Diseases of Women and Children*, volume xxiii., No. 3. 1890.

New Methods of Performing Pylorectomy, with Remarks upon Intestinal Anastomotic Operations. By A. V. L. BROKAW, M. D., St. Louis, Mo. Reprinted from the *St. Louis Courier of Medicine*, June, 1890.

Miscellany.

THE USE OF WATER AT MEALS.

Opinions differ as to the effect of the free ingestion of water at meal times, but the view most generally received is probably that it dilutes the gastric juice and so retards digestion. Apart from the fact that a moderate delay in the process is by no means a disadvantage, as Sir William Roberts has shown in his explanation of the popularity of tea and coffee, it is more than doubtful whether any such effect is in reality produced. When ingested during meals, water may do good by washing out the digested food and by exposing the undigested part more thoroughly to the action of the digestive ferments. Pepsin is a catalytic body, and a given quantity will work almost indefinitely, provided the peptones are removed, as they are formed. The good effects of water, drunk freely before meals, has, however, another beneficial result—it washes away the mucus which is secreted by the mucous membrane during the intervals of repose, and favors peristalsis of the whole alimentary tract. The membrane thus cleansed is in a much better condition to receive food and convert it into soluble compounds. The accumulation of mucus is especially well marked in the morning, when the gastric walls are covered with a thick, tenacious layer. Food entering the stomach at this time will become covered with this

tenacious coating, which for a time protects it from the action of the gastric ferment, and so retards digestion. The tubular contracted stomach, with its puckered mucus lining and viscid consents, a normal condition in the morning before breakfast, is not suitable to receive food. Exercise before partaking of a meal stimulates the circulation of the blood and facilitates the flow of blood through the vessels. A glass of water washes out the mucus, partially distends the stomach, wakes up peristalsis, and prepares the alimentary canal for the morning meal. Observation has shown that non-irritating liquids pass through the "tubular" stomach, and even if food be present they only mix with it to a slight extent. According to Dr. Leuf, who has made this subject a special study, cold water should be given to persons who have sufficient vitality to react, and hot water to others. In chronic gastric-catarrh it is extremely beneficial to drink warm or hot water before meals, and salt is said in most cases to add to the good effect produced.

—*British Medical Journal.*

THE TREATMENT OF FLATULENT DYSPEPSIA.

In *Les Nouveaux Remèdes*, April 8, 1890, Dr. Huchard publishes a number of formulæ, which are claimed to be of value in the treatment of dyspepsia, especially with a view of preventing the development of flatulence. Among the remedies which the author has found most satisfactory, chloroform is the best. On account of its irritant action it should not be given in a state of purity or in capsules, as is so frequently done. The best mixture is claimed to be its administration in saturated chloroform water.

Saturated chloroform-water, 150 parts;
Distilled water, 120 parts;
Mint-water, 30 parts.

Of this mixture a tablespoonful may be taken either immediately before or during a meal.

The same dose may also be taken of the following formula:

Saturated chloroform water, 140 parts;
Orange-flower water, 150 parts;
Tincture star-anise (*Illicium anisatum*),
[10 parts.

In the following preparation the chloroform is associated with gastric stimulants:

Tincture of gentian,
Tincture of anise,
Tincture of nux vomica, $\text{aa } 3\text{i}$;
Chloroform-water, 20 to 40 drops.

After filtration, 10 to 20 drops of the above may be taken in a little water a quarter of an hour before eating.

When it is desired to employ the so-called absorbing powders the following formulæ may be prescribed.

Powdered charcoal, 3ii ;
Sodium bicarbonate, $3\text{i}\frac{1}{2}$;
Calcined magnesia, 3i ;
Powdered colombo, 3ss .

Make 40 powders. One powder may be taken half an hour before, or, if an antiseptic action is desired, at the time of, eating.

Beta-naphthol.
Salicylate of bismuth,
Magnesia, aa gr. xlvi .

Make 30 powders, which may be administered as above.—*Ther. Gaz.*

TO PREVENT DISCOLORATION IN BRUISES.

To prevent the blood from settling under a bruise, there is nothing to compare with the tincture or a strong infusion of capsicum annum mixed with an equal bulk of mucilage of gum-arabic, and with the addition of a few drops of glycerin. This should be painted all over the surface with a camel's-hair pencil and allowed to dry on, a second or third coating being applied as soon as the first is dry. If done as soon as the injury is inflicted, this treatment will invariably

prevent the blackening of the bruised tissue. The same remedy has no equal in rheumatic stiff neck.—*St. Louis Poly-clinic*.—*Therapeutic Gazette*.

THE ADMINISTRATION OF TURPENTINE IN TYPHOID FEVER.

Dr. H. C. Wood recommends the following formula as satisfactory:

R.—Ol. caryophylli,	gtt. vj.
Ol. terebinth	3 jss.
Glycerin.	
Mucil. acaciæ, aa,	3 ss.
Syrupi.	
Aquaæ aa q. s. ad	3 iij.

M.—Sig: Dessertspoonful every two hours.—*Pittsburgh Med. Review*.

DIABETES IN CHILDREN.

Dr. Stern, of Berlin, has collected 117 cases of diabetes in children, and thinks that this affection is by no means so rare in childhood as is frequently supposed.

The girls in his list are more numerous than the boys, the proportion being five to three. No age would appear to be free. Six of the cases occurred in infants under a year old. The parents of the affected children were in some cases themselves diabetic, but in many more instances they were suffering from some neurotic trouble. The disease in many cases seemed to have come on after gastric catarrh, purpura, measles, or concussion of the brain. As to the prognosis, he finds that three-fourths of the cases were fatal, as was every case in which the affection had lasted for a year or more. The disease did not appear to run a more rapid course in younger than in older children.—*Lancet*.

Medical Items.

A large veterinary hospital has been opened on Harford Avenue.

Dr. and Mrs. Frank West have returned from Bermuda and will settle in Baltimore.

Dr. A. A. Roth, said to be a prominent homœopathic physician of Annapolis, is dead.

Medical students in England are raising a strong objection to the addition of a fifth year to the curriculum.

The Earl of Meath, in an article on "The Lungs of our Great Cities," praises very highly Druid Hill Park, which he frequently saw on his visit here this spring.

Dr. G. W. Barr, of Bridgeport, Ill. (*Therapeutic Gazette*, June 16, 1890), says that flavoring additions to cigars do more harm to the smoker than the tobacco itself. He also finds tea harmless when strained and iced.

By an unavoidable accident, Dr. Geo. H. Rohé and wife were thrown from their carriage last Monday afternoon while driving in the park. They fortunately escaped with nothing worse than a few bruises and scratches.

The dangers of giving medicine without a physician's advice is shown in the man, who, a few days ago in this city, gave his son successive heroic doses of wormseed oil (ol. chenopodii) for cholera-morbus, the second or third dose proving fatal.

Dr. E. Oliver Belt, formerly of the Staff of the Presbyterian Eye, Ear, and Throat Charity Hospital, has been appointed Lecturer on Diseases of the Eye and Ear in the Medical Department of Howard University, Washington, D. C. His office is at 1313 H Street, N. W.

By a new regulation recently made by the Senate of the University of Vienna, students on matriculating must present the Dean of the Faculty which they wish to enter with their photographs. These works of art will be used to identify

candidates when interesting questions as to "signing up," etc., arise.

Dr. Robert B. Morison will sail next month for Europe and will attend the meeting of the British Medical Association, at Birmingham where he has been invited to take part in the discussion on alopecia areata and eczema. He will later go to the International Medical Congress at Berlin.

Oliver Wendell Holmes, in "Over the Teacups," in the *Atlantic Monthly* for July, denies that he ever gave utterance to the foolish statement with which the *Journal of the American Medical Association* gives him credit. The alleged statement was, "Give me opium, wine and milk and I will cure all the diseases to which human flesh is heir."

It is said that the physicians of New York are criticising Dr. Gibier of the New York Pasteur Institute for his large number of alleged cures, thus advertising himself widely, while it is claimed that hydrophobia is a very rare disease, and that few of the cases treated by him would show signs of the disease if let alone. A wealthy man has offered a building for the institution, and his offer will probably be accepted.

Scarlet fever and diphtheria are very prevalent in the town of Highlands, near Denver, Col., and the citizens are becoming almost panic-stricken. Among other measures taken to improve the health of the community and to prevent further spread of contagion, warrants have been issued for the arrest of a number of physicians who have failed to report cases of diphtheria and scarlet fever occurring in their practice.

The *Baltimore Sun* of Thursday last has a "local" on Dr. Osler and his case of hepatic abscess with amoebæ, as noticed in the *London Lancet* of June 7th. As Dr. Osler's reputation needs no bolstering by the daily press, and as readers of a daily paper care little about dysenteric

amoebæ and hepatic abscesses, the notice is in extremely bad taste. It is to be hoped that the Johns Hopkins Hospital does not endorse this method of advertising its staff.

From the organization of the Medical Examining Board of Virginia, January 1st, 1885, to April 10th, 1890, the following statistics are given in the *Virginia Medical Monthly* for June, 1890: College of Physicians and Surgeons: 45 applicants; 30 passed, 13 failed on the first examination, of which 6 were re-examined, and 2 failed. University of Maryland: 53 applicants; 34 passed, 19 failed on first examination, of which 4 were re-examined, and 2 failed. Baltimore Medical College: 3 applicants; none passed. Baltimore University School of Medicine: 3 applicants; none passed. At the examination held April 9th and 10th, 1890, of two applicants from the University of Maryland, 1 passed.* Of 4 from the College of Physicians and Surgeons, 3 passed, and the one applicant from the Baltimore University School of Medicine failed to pass. The Baltimore Medical College had no applicants at this examination.

In looking over the grades of the rejected candidates from the three former schools, the lowest grades were taken in chemistry and physiology, which seems to be the weakest points in all the schools, judging from these grades. The College of Physicians and Surgeons shows the highest grade in hygiene and medical jurisprudence, *materia medica* and therapeutics, obstetrics and gynaecology; the lowest in chemistry and physiology. The University of Maryland has the best grade in hygiene and medical jurisprudence, *materia medica* and therapeutics, and surgery; and the lowest in physiology, anatomy and chemistry. The Baltimore University is about the same. All the applicants were said to be very defective in the English branches, particularly in the rudiments of spelling and grammar.

*The Dean of the University of Maryland says that both applicants passed.

MARYLAND MEDICAL JOURNAL,

VOL. XXIII. No. 10.

BALTIMORE, JULY 5, 1890.

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ONE HUNDRED CONSECUTIVE CASES OF LABOR AT THE MARYLAND MATERNITÉ, WITH A DESCRIPTION OF THE METHODS PRACTISED IN THAT INSTITUTION.*

BY GEORGE H. ROHÉ, M. D.,

Director,

AND WM. J. TODD, M. D.,

Resident Physician.

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the Maryland Maternité, Baltimore, Maryland.

To this is added a summary of one hundred consecutive cases occurring from May 3rd, 1889, to January 22nd, 1890, inclusive.

In the institution mentioned, practical obstetrics is taught to about three hundred students yearly. This, and also the bad hygienic condition of the majority of the patients admitted, and of the homes they come from, render the strictest observance of the latest antiseptic precautions necessary for the prevention of diseases peculiar to the lying-in period.

Adding to the above disadvantages, the fact that about twenty per cent. of the patients are confined within the first twenty-four hours after they are admitted increases this necessity.

Of the above named twenty per cent. perhaps one half are admitted when in the second stage of labor, hardly giving enough time to undress the patient and place her in the bed.

*Read before the Medical and Chirurgical Faculty of Maryland, at its 91st annual session, April 23, 1890.

The patient when applying for the benefits of this charity, is encouraged to tell the history of her pregnancy. She is then taken to a vacant ward; her breasts and abdomen are inspected; the condition of the cervix is ascertained by vaginal touch. Here the antiseptic precautions begin: The physician's hands are washed in the ordinary way in hot water, scrubbed with a nail brush, then immersed in a solution of bi-chloride of mercury of the strength of 1 to 2000, and lubricated with olive oil.

In the majority of cases, an ocular examination of the pudendum is also made.

The legs are examined for ulcers, varicosed veins, and scars of old lesions.

The pelvis externally, is measured with a pelvimeter. The diameters between the anterior superior spinous processes, the widest part of the iliac crests, and the external conjugate diameters are taken.

These figures, with a memorandum of the name, age, color, nativity, number of pregnancy, and the date of the last menstruation of the patient are noted.

If her expected confinement is more than two or three weeks off, she is given a card admitting her on or before a certain fixed date, which usually allows her about two weeks in the hospital before her confinement.

This card instructs her to return to the hospital immediately upon the first symptoms of labor, if they should come on before the date fixed. It further instructs her as to what clothing to bring and what not to bring to the hospital.

When admitted to the hospital the patient is taken to the bath-room; here she is required to take a full bath under the direction, inspection, and assistance of a nurse.

If she does not have clean under-clothing, this is furnished to her; also a clean wrapper.

Corsets are forbidden during the patient's stay in the hospital.

A tight-fitting waist or jacket, with two or three rows of buttons around the waist, from which to suspend the skirts, is recommended.

Where this jacket has been tried it has proved a success and a comfort to the wearer.

One hour before breakfast each morning sulphate of magnesia is given to the newly admitted patient.

This hygienic precaution is necessary, as more than seventy-five per cent. of the patients admitted are constipated to a greater or less degree.

During the time between her admittance to the hospital and her confinement, the patient is required to take a full bath twice a week. On the second or third day after the patient has been admitted, her urine is examined. The specific gravity and the reaction are taken, a test for albumen and sugar is also made, and the percentage of chlorides is noted.

If the sample of urine is found to be normal, a second examination is not made until the first day after labor, or symptoms are developed that would suggest an examination. Should there be any abnormality about the urine, the patient is watched closely, and the urine is tested frequently. On the eighth day after confinement, the urine is again examined.

Immediately after the beginning of the first stage of labor, the patient is given a full bath.

If this stage has progressed too far to admit of such an exertion upon the part of the patient, or the labor is likely to progress rapidly, the patient is washed by the nurse from the mammary glands to the knees.

She is given an enema to unload the bowels, followed by a vaginal douche of a solution of bi-chloride of mercury, 1-4000. This last being repeated, if thought necessary, two or three times.

The attendants making vaginal examinations are required to use the nail brush freely, with plenty of hot water and soap.

After drying the hands and forearms on a clean towel, they are immersed in a solution of bi-chloride of mercury, 1-2000. So much of this solution as will, is allowed to remain on the hands.

Carbolized olive oil is used to lubricate the fingers of the examining hand.

The above precautions are carried out before each and every vaginal examination.

It is also recommended that the space under the finger nails be filled in with soap; also around the junction of the nail and skin.

This, while being an additional precaution against the infection of the patient by the examiner, also affords protection to the examiner against any possible infection of his fingers by discharges from the patient.

Puncture of the Membranes.—It was the rule in the early part of the year to puncture the membranes when the os was fully dilated, but during the last six months it has been thought best not to interfere with the possible good they might do as a dilator, and allow the sac to rupture of itself, or to puncture it when it makes its appearance at the vulva.

During the first stage of labor, the patient is allowed to walk around the room, or remain in bed, as she may elect. During the second stage she is placed in bed and required to remain there.

It is the endeavor of the physicians to control the patient as to "bearing down."

The perineum is supported with the left hand, and the coming head is held in check by the fingers of the right hand.

All lacerations of the perineum are sewed up immediately, or within eight hours, with silk thread.

After the head is born the fundus of the uterus is followed up by the hand of the nurse. As the proper shoulder comes down on the perineum, the left hand is again placed to support it while the right lifts the head of the child upward to the symphysis pubis.

In a number of cases the shoulders of the child have lacerated the perineum which had remained intact after the passage of the head.

The child is placed upon its right side, its eyes and mouth are wiped dry with a clean soft towel.

Allowing the infant to breathe fully for one or two minutes, and the pulsation of the cord to cease, two ligatures are placed on the cord and the latter divided between the ligatures.

The attendant then places his hand on the abdomen over the fundus of the uterus.

After waiting about fifteen minutes he makes a gentle kneading motion with his fingers over the fundus; this causes further contractions of the uterus.

No traction is made on the funis; it remains on the bed as it fell after being severed from the infant.

The presenting side of the placenta is easily noticed at the vaginal orifice—this side is noted; it is then twisted so that a cord is formed of the after coming membranes which soon drop out on the bed.

The placenta is then examined. If any part is remaining in the vagina or uterus, the attendant, immersing his hand in a solution of bichloride of mercury, places it in the vagina, or if necessary, into the uterus and empties it.

If there is any indication of haemorrhage, ergot is given hypodermically, but if there be no haemorrhage, ergot is not given.

The hand of the nurse remains on the abdomen over the fundus of the uterus for fifteen to thirty minutes after the physician leaves the case in her charge.

The patient is made as comfortable as possible, and is allowed to rest twenty to thirty minutes. She is then given a vaginal douche of a hot solution of bichloride of mercury 1-4000.

All parts of the person that have been soiled by blood or discharge are washed; clean linen is put on the patient.

The lips of the vulva are parted and a powder of iodoform and boracic acid thrown in as far as possible, a wad of sublimated (1-1000) jute or hemp is then placed over the vulva, then a large muslin pad.

The patient is then lifted off the confinement bed and placed in a clean and freshly prepared bed.

Twice daily foreight or nine days the patient is washed, iodoform and bora-

cic acid powder used, a new wad of sub-limated hemp applied and the under pad changed.

The bed and body linen are changed entire at the morning bath, and the soiled clothing disinfected in bichloride solution and boiled.

The lochial discharge is noticed particularly as to color, odor and quantity.

The pulse and temperature of the mother are taken twice a day at 9 A. M. and 7 P. M.

On the evening of the third day, or morning of the fourth day, one ounce of sulphate of magnesia is given to unload the alimentary canal. This is repeated during her stay in bed as is necessary.

The ninth day after labor, if the condition of the patient will admit, she is allowed to sit up in an easy chair three hours, divided into periods of one hour in length.

The morning of the tenth day her condition is noted before she is allowed out of bed. If favorable, she is allowed to use her pleasure as to when and how long she may rest in bed or in the easy chair.

On the 14th day, if her recovery has been complete, she is discharged, to return to her home or to her friends, with caution as to the care she must take of herself.

Diet of the Mother.—For the first day, toast and a soft-boiled egg with tea or coffee.

The second day, a small piece of meat is added, after this a general diet is allowed.

The Child.—The cord being properly tied, the infant is handed to a nurse, who has a warmed blanket ready to receive it.

She places it in a safe place taking care that it is lying on its right side.

A clinical thermometer is placed in the rectum and the temperature registered is noted.

After the mother has been washed and placed in a new clean bed, the infant is weighed and measured.

The occipito-frontal, the occipito-men-tal, the sub-occipito-bregmatic, and bi-

parietal diameters are taken, also the occipito-frontal and sub-occipito-bregmatic circumferences, as well as the circumferences of the shoulders and hips.

The length of the infant is also noted.

While all this is being done, the greatest care is taken to keep the infant as warm as possible. Finally, before turning the infant over to the nurse to be washed and dressed, a few drops of a solution of nitrate of silver of the strength of grains v to the $\frac{3}{4}$ i, are dropped into its eyes as a prophylactic measure against ophthalmia neonatorum.

The nurse taking charge of the infant, immediately examines the stump of the funis, places a second ligature about half an inch back of the one already on. She then anoints the infant with olive oil and washes it in the usual way with hot water and soap.

The stump of the cord is then dressed with absorbent cotton dusted with iodof orm.

After dressing the infant it is placed to the mother's breast.

All infants are washed and dressed twice a day, morning and evening.

All clothing is changed throughout at the morning bath, and the necessary changes of napkins are made during the day.

Cradles are provided and the nurses are expected to keep the infants in them, except when nursed by the mother.

The weight of the infant is taken at birth, and again on the third and sixth days, also on the day of discharge.

On the fourth day the diameters and circumferences of the head, as named above, are again taken.

The Bed.—In cases for demonstration, the bedstead is one made of iron, thirty inches wide, twenty-six inches high, and six feet six inches long.

A husk mattress is placed upon it, then covered with a rubber blanket, and the usual sheets, etc.

This high bedstead affords every opportunity for those that are spectators to observe the different steps of the labor and care for the mother and infant. It

gives the attending physician full control of the patient, also is a great saving to his own back, this last being no small consideration,

It is a cardinal rule, the observation of which is positively insisted upon, that during the second stage of labor a good supply of boiling water shall be near at hand; that a clean syringe with a vaginal tube is within sight, so that if a post-mortem haemorrhage should occur, no delay will be necessary in stopping the flow of blood.

A hypodermic syringe is also filled with fluid extract of ergot, and is near at hand. The above precautions are taken in every case.

The placenta after being examined by the attendant to ascertain that it is intact, is placed in a vessel containing a solution of bichloride of mercury 1-2000.

After the infant has been weighed, etc., the placenta is weighed, measured and a diagram of its shape is made. It is then replaced in the bichloride of mercury solution and then taken from the room and burnt.

The clothes, all the bed and body linen of the patient, and towels, napkins, etc., are taken immediately to the laundry. After being washed and boiled, the linen is placed in a strong solution of bichloride of mercury, for not less than two hours, then wrung out dry and placed on a line.

All linen that has been soiled by blood or discharges at other times is treated in the same way.

Absolute cleanliness is exacted of all in the hospital.

The nurses wear dresses of washable material. None of the floors in the wards or confinement rooms are carpeted.

All floors and staircases are washed three times a week with water and soap. When dry, they are washed a second time with a solution of bichloride of mercury only.

Any one visiting the dissecting rooms, or who has lately assisted at a post-mortem examination is not allowed to enter the confinement room.

(To be continued.)

PENETRATING WOUND OF THE COMMON FEMORAL VEIN AND FEMORAL RING. LIGATURE OF THE FEMORAL AND INTERNAL ILIAC VEINS.

RECOVERY.*

BY ROSS P. COX, M. D.,

Resident Surgeon, St. Agnes's Hospital, Philadelphia.

W. C., aged twenty-two years, male, cabinet-maker, was admitted to St. Agnes's Hospital, July 15, 1889. Half an hour before admission, while he was pushing a piece of hard wood through a moulding machine, by the aid of a stick three-quarters of an inch broad and half an inch thick, resting against his right groin, the blade struck a knot and forced the bits of wood backward with such energy as "to double him up and almost knock him down." The stick had perforated the several layers of thick, strong clothing, and inflicted the injuries described below, but fell to the floor unbroken. He experienced some pain, but suffered more from fright and shock. Almost immediately a swelling appeared at the point of puncture. On entering the hospital he showed considerable excitement and moderate shock,

There was a tumor about as large as a hen's egg at the centre of Poupart's ligament, and extending somewhat above it. Near the centre of this enlargement there was a slit, extending transversely about half an inch. Less than an ounce of blood had been lost, and bleeding had ceased.

After slightly extending the wound outward and upward, the probe, not before entering more than an inch, could readily be carried inward and slightly downward for two inches and three-quarters; slight venous bleeding followed its withdrawal.

The situation of the wound and the direction taken by the probe indicated the possible penetration of the abdominal

*Read before the Philadelphia County Medical Society, May 14, 1890.

cavity and involvement of some viscus.

Professor W. W. Keen, the surgeon on duty, was summoned, and arrived in half an hour. The area of operation had meanwhile been shaved, scrubbed with hot water and soap, rinsed, bathed with ether, and finally with 1-1000 bichloride solution, in anticipation of surgical interference.

After examining the injury, Dr. Keen determined to enlarge the wound and explore its nature and extent.

Operation.—Ether. The incision was extended slightly upward, but chiefly downward and inward, as the probe indicated that direction. The successive layers of skin and fasciae were divided until the finger could be carried deeply into the wound. Poupart's ligament was detected just at the upper border of the wound. At a depth of two inches the tip of the probing finger entered a perforation in what felt like a thin membrane, just internal to the pulsating artery. The bleeding had now become rather free, and the withdrawal of the finger was followed by a copious gush that left no doubt that its source was the femoral vein. While the haemorrhage was controlled by a finger in the opening, the wound was enlarged. Poupart's ligament, the injured vein and its homologous artery were exposed to view. The artery was black from the extravasated blood, but seemed firm to the touch. No tear of its walls was perceptible, but it was not unlikely that it had been struck. Further observation showed that the vein had been pierced through both its anterior and posterior walls, and that the abdominal cavity had been entered through the femoral ring. The finger could be carried through the ring into the abdominal cavity for about an inch; but there seemed to be no rent in the peritoneum. Something could be felt by the finger-tip, probably intestine, but it was intact.

The vein was secured below and, with some difficulty, above the lesion by means of two haemostatic forceps, and divided between these instruments. A medium-

sized aseptic silk ligature was quickly and firmly applied to the peripheral end of the vessel. To similarly secure the proximal end was a work of some difficulty; in fact, it was the external iliac vein that was here tied. Considerable traction to draw the vein down, and still more to lift Poupart's ligament up with a retractor, had to be used before it was accessible. After tying a few small vessels that the forceps failed to close permanently, the clots were removed, and the entire wound irrigated with weak bichloride solution. The ligating threads were cut off close to the knots. Thorough drainage was secured by a small fenestrated rubber tube extending from the bottom of the wound to the inferior angle externally, and by a horsehair drain extending superficially from angle to angle.

The incision of the skin was about four inches long. Its lips were approximated by silk suture. A generous dressing of dry 1-1000 bichloride gauze was applied, and gentle compression made by a spica bandage of the groin. The operation lasted nearly an hour. The affected limb was elevated to 35° from the horizontal and well wrapped in cotton-wool, gently retained by a roller. Bottles of hot water were placed around it and elsewhere. He was given cracked ice and one-sixth of a grain of morph. sulph. hypodermically.

A diet of four fluidounces of milk every two hours was directed to begin six hours subsequent to operation.

July 16th, six hours after operation, I was called to him. The dressing was found to be saturated with blood; about one pint of blood had been lost. He showed much anxiety and restlessness; pulse rapid but fairly good; temperature not much changed. The dressing was removed, and it was ascertained that the bleeding had ceased. The rubber tube had disappeared in the wound, but the outlet had apparently been free, and there was no perceptible accumulation of clots. The bleeding was probably from a small branch that opened into the vein

at some point between the ligatures. A fresh dressing with slightly firmer compression was made. Considerable oedema of the extremity was observed. Cyanosis of the leg, which had been noticeable immediately after the vein's occlusion, was marked. One-eighth of a grain of morph. sulph., and one two-hundredth of a grain of atrop. sulph. was administered hypodermically.

After he had tried unsuccessfully to evacuate his bladder, he was catheterized at 5.30 A. M. Urine was free from blood. Morning temperature 99° F. Pulse 84. Fifteen hours after operation the temperature of each thigh was found to be 94° F. Subsequent observations did not vary materially from this record. The cyanosis gradually diminished.

Wound was redressed; no more haemorrhage; doing well; urine drawn every six hours. A rather tight stricture of the membranous urethra rendered catheterization tedious and painful. Diet of four fluidounces of milk every two hours continued. There was but little pain, and this was referred almost entirely to the right loin. The swelling persisted; its extension below the ankle was not very considerable.

The posterior tibial artery pulse at the ankle was feeble, but perceptible. Evening temperature 100° F., pulse 91. Was given one-quarter of a grain of morph. sulph.

17th. Free movement of bowels procured by one-drachm doses of salts given hourly, as required. Pain in loin persists; he is a little restless. Wound dressed; its condition was excellent. Continued use of catheter; diet unchanged. Not much cyanosis remained; oedema lessening slightly; artificial heat discontinued entirely. Temperature reached its maximum, 100.8° F., pulse 96.

19th. Daily dressing and previous treatment continued. The rubber drainage-tube was removed. Perfect asepsis maintained.

20th. Two normal evacuations of bladder; color of skin of the affected limb

about normal; oedema greatly diminished; limb lowered to the horizontal; pain moderate; it has left right lumbar region and is felt in the wound for first time.

Bowels moved by Epsom salts; doing well in every way.

21st. Use of catheter discontinued; no pain; rests well; diet continued; lowering of limb followed by no marked increase of oedema.

23rd. Continued daily dressing of wound; the discharge consists of about one fluidrachm of sero-pus; healing progressing satisfactorily; removal of superficial horsehair drain; light diet.

28th. Two of the stitches removed; the cotton padding around limb taken off; swelling not marked.

August 1st. Last stitch taken out; small horsehair drain inserted in wound.

8th. Daily dressing continued; horsehair gradually removed; about half a fluidrachm of pus escapes daily.

16th. Sat up part of day.

20th. Sat up all day.

27th. Discharged. He walks with a slight limp. Wound healed, except at site of drainage; scarcely any discharge.

September 19th. Healing complete. Some swelling after prolonged walking or standing; some stiffness remains. The lower limbs are of equal size on rising in the morning; has returned to work that requires constant standing; general health excellent.

January 17th, 1890. For four months he has steadily pursued his avocation, with no other discomfort than slight oedema and stiffness, that are constantly lessening.

April 4th. Is entirely relieved of all oedema and stiffness, and suffers no inconvenience whatever from the injury.

In conclusion, I wish to set forth some of the facts with regard to treatment and results of wounds of the common femoral vein as taught by cases collected from all possible sources, and tabulated by me:*

*For these cases I am chiefly indebted to the papers of H. Braun, Archiv. f. klin. Chir., vol. xxviii, p. 620; Koretsky, Archiv. f. klin. Chir., vol. xxxvi, p. 617. Maibrac, Archiv. Général, Jan. 1889; Walsh, Trans. Med. and Chir., vol. lxxi, p. 237; Med. and Surg. Hist. of War of the Rebellion,

a. Wounds of common femoral vein, not done in tumor operations, treated by immediate ligation of vein; 3 cases, including the case I have reported, 2 deaths from gangrene, and 1 recovery (the present case).

b. Ligation of common femoral vein for wounds, not made in tumor operations, after trying and failing with compression; 2 cases, 1 death from septicæmia, and 1 recovery.

c. 29 cases of ligation of common femoral vein, wounded in extirpation of tumor; 16 recovered and 10 died. Of the 10 deaths, 3 were from haemorrhage, 2 from recurrence of malignant growth, 2 from pulmonary oedema, 1 from exhaustion, and 1 from limited gangrene and exhaustion, and a man forty-nine years old infected by sarcoma,

d. 27 cases of ligation of the common femoral artery or external iliac artery, and the homologous vein, for wounds made in tumor operations, give six recoveries and 21 deaths. Of the 21 deaths, 12 were from gangrene, 4 from septicæmia, and 1 each from haemorrhage, recurrence of growth, pyæmia, and pneumonia. The cause of death of one case was not given.

e. Wounds of the common femoral vein, not made in tumor operations, treated by ligation of the homologous artery only: 5 cases, 5 deaths; one each from septicæmia, gangrene, shock and exhaustion, and in one instance no cause was given.

f. Wounds of common femoral vein, not made in tumor operations, treated by ligation of both artery and vein: 17 cases, giving 6 recoveries and 11 deaths. Of the 11 deaths, 5 were from gangrene, 4 had no cause assigned, and 2 were from haemorrhage,

g. Wounds of common femoral vein treated by lateral ligation: 3 cases, with 1 death from haemorrhage, and 2 recoveries.

h. Wounds of common femoral vein, not treated by ligation of either vein or artery: 11 cases, 11 deaths; 4 from causes not given, 3 from haemorrhage, and 2 each from pyæmia and gangrene.

PULMONARY GANGRENE.

BY E. S. MCKEE, M. D.,
OF CINCINNATI.

Malagola* reports the case of a patient who was admitted with intermittent fever, symptoms of gangrene of the lung intervening. Intra-pulmonary injections of various antiseptics were tried. The condition of the patient daily became worse, and a drairage tube was introduced. An incision was made in the intercostal space immediately under the right nipple. The drainage tube, two millimetres in diameter, was inserted for five centimetres, and every three hours was washed out with a five per cent. solution of carbolic acid. As this caused violent cough and vomiting, the sublimate solution five per cent. in 1,000 was substituted. This was well borne and caused but little cough. All the severe respiratory and circulatory phenomena diminished rapidly and the general health of the patient immediately improved. After the fourth day the drainage tube showed a tendency to be expelled. It was gradually shortened and finally taken out on the 19th day. The patient was admitted June 25th, and left the hospital quite well September 15th. There was a distinct falling in of the wall of the chest on the operated side between the clavicle and nipple.

Squire † had a case, in which besides the characteristic intense odor of the expectoration there were the signs of consolidation, followed by the formation of a cavity in the seventh and eighth intercostal spaces on the right side, just within the lower angle of the scapula. The points in the treatment which merit special mention were: the use of a respirator with carbolic acid and the free ventilation of the room. An oro-nasal respirator was constantly worn and cups of carbolic acid were placed about the room. He invariably uses carbolic respirators when the expectoration is foul, and the relief to

*Malagola, London Medical Record, July 20th, 1889.
Revisita Clinica, May 1889.

†Squire, London Lancet, July 20th, 1889

the patient is as marked as to his companions. He was kept on brandy, a liquid diet and a tonic mixture containing quinine. The patient recovered.

Society Reports.

MEDICAL AND SURGICAL SOCIETY OF BALTIMORE.

STATED MEETING HELD MARCH 13, 1890.

The 708th regular meeting of the Society was called to order, Dr. H. T. Reynolds in the chair.

Dr. Randolph Winslow exhibited several

SPECIMENS ILLUSTRATIVE OF INFLAMM- MATORY DISEASES OF THE UTERINE APPENDAGES.

He said he thought this a good subject to discuss in a Baltimore Medical Society, as Baltimore was a stronghold of the idea of pelvic cellulitis. He had only recently gotten his mind clear of this idea. He had been taught that the symptoms of pelvic cellulitis were fever, chill, pain in the pelvis and a felling or condition of board-like hardness in the pelvis. As a result of gonorrhœa a female may present these symptoms, the inflammation may travel up from the vagina to the uterus, to the tubes and thus set up a salpingitis. This is a condition rarely recovered from and is most likely caused by gonorrhœa. It is easy to see how an inflammation may be set up by the introduction of dirty instruments or unclean hands, and it may be accepted as proven that pelvic cellulitis does not occur primarily, but is secondary. A pus tube may burst and produce a general peritonitis or a local peritonitis with the agglutination of the surrounding parts. The first specimen is pus tubes. This case was treated by a prominent gynaecologist

as a case of pelvic cellulitis. Dr. Winslow thought the primary cause was a gonorrhœa. She finally fell under his care, and having gotten rid of the idea of pelvic cellulitis, he looked for another cause as the source of her trouble. Pus tubes was diagnosed and an operation was performed. The patient was 29 years of age. She made a good recovery and has no trouble now, except the flushing of the menopause. She was operated on in May 1889, and he thought it was the first case recognized and operated on in Baltimore.

The second specimen is hydrosalpinx. Patient æt. 27. She was the abandoned wife of a sporting man. She had a pre-fuse discharge, she could not work, she had pain, nausea, and was generally broken up. After an examination she was compelled to keep her bed for several days. The outcry of unsexing a woman in this condition is without foundation, she is already unsexed and it is impossible for a woman in this condition to bear children, as the specimen will show.

The third specimen is also hydrosalpinx. The tube is large, with numerous cysts attached to it. The fourth specimen is the same as the second and third. These cases showed marked peritonitis, and all of them had numerous adhesions.

The fifth specimen is a puse tube. In this case gonorrhœa was not suspected at first, but later developments point to that as the probable cause. She was 29 and gave the history of having "caught cold" four years before. She had peritonitis and was ill for weeks and weeks; finally she got out. This fall she came under Dr. Winslow's care and she was operated on. Only one tube and ovary was removed, and no trouble has followed. In answer to inquiries, Dr. Winslow said that the diagnosis was made in several cases by plainly feeling the pus tubes. That he did not believe in a pelvic cellulitis except as secondary affection. That sometimes the diagnosis can be made without an anæsthetic, but in those very sensitive cases spoken of, it is best to use an anæsthetic to make a positive diagnosis.

Dr. J. W. Chambers said that operation was the only proper thing to do in those cases where the condition is recognized. And where one is in doubt, he thought it justifiable to cut down and explore. He did not agree with Dr. Winslow in, that a hydrosalpinx could be caused by a gonorrhœa. If a salpingitis is caused by a gonorrhœa, he thought it ought to be a pyosalpinx, and not a hydrosalpix. He thought it quite possible that some women suffering from acute pelvic cellulitis or peritonitis, or salpingitis, do recover, and that without operation. If they do recover, the organs then function properly and they then bear children. He congratulated Dr. Winslow on exhibiting so many pathological specimens. The specimens are pathological, not from a gynæcological, but a pathological standpoint.

Dr. Frank C. Bressler said he thought it dubious as to a pelvic cellulitis always being a secondary affection. If it be secondary, why is it not bilateral, instead of unilateral, as it usually is? He had a case of pelvic cellulitis following an abortion. He thought he was the cause of the attack. In washing out the uterus with an antiseptic solution, he must have gotten some of the water in the tubes, for the patient immediately became collapsed. Now, when is the time to operate on a case of this kind? All inflammations can spread by contiguity as well as by continuity, and we may have these conditions set up by injuries following abortions or by use of instruments. He would ask Dr. Winslow if he had ever tried massage, as recommended by Brand?

Dr. Randolph Winslow said in conclusion, of course we may have an abscess or an acute phlegmon in the pelvis as well as anywhere else. In pyosalpinx the fimbriated extremity becomes occluded. We may have cases of peritonitis that are recovered from. These acute cases are to be treated by hot fomentations, rest and opiates or salines, but he was not discussing acute cases, it is in chronic

inflammatory troubles, that he advises operations. When you recognize a pyosalpinx, he thought the only thing to do was to operate. As to Brand's method of massage and friction, he had not tried it, and never would; he thought it a filthy, dirty practice, and too much like masturbation.

Dr. J. W. Chambers exhibited a

SPECIMEN OF MULTIPLE ENCHONDROMA.

He said the specimen was interesting because of its size. No reasonable person would have allowed it to grow so long. It began as a painless, gradual enlargement of the thumb of the left hand, at ten years of age, and had it been cut down upon and enucleated just as though it were a sequestrum, his hand might have been saved, but it was allowed to grow to this enormous size until the patient was 44 years old when the amputation was done. Enchondroma is not malignant. According to Bryant and others, they are more apt to involve the phalanges of the upper and lower extremity. They may also occur in the clavicle, scapula, femur, parotid gland and testicle. The family history of the patient was good. The growth gave him no trouble until about a year or so ago, it began to pain when some of the cysts began to break down. These cysts contained the characteristic dark, bloody fluid.

Dr. A. T. Shertzer said about two weeks ago he operated on two, in the hands of a lady. There were central, not periosteal. He laid them open freely and scraped them out. She is doing well.

J. WM. FUNCK, M. D., Sec'y,
1710 West Fayette Street.

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BALTIMORE, JULY 5, 1890.

Editorial.**ON SWELLED-HEAD.**

(CHRONIC FORM.)

Chronic Swelled-head (Megalokephale) differs in many particulars from the Acute variety, yet it is evident on careful investigation, that it is due to the same germ or morbid influence as the latter, the differences resulting from the natural peculiarities of the affected tissues. The disease runs an *acute* course in the one case, because the tissues are naturally healthy and of good quality; its course in the other case is *chronic* because the affected nerve elements are congenitally weak, or because they have been unfitted by the previous life of the patient for the sudden strain thrown upon

them. Practically the pathology of both forms is equally obscure.

There are two varieties of the chronic form generally seen: the *congenital* variety, in which the patient from childhood or from the onset of puberty, manifests perverted views concerning his own importance in the community, adopting various bizarre methods of speech or dress, and exhibiting a chronic enfeeblement of the receptive faculties as far as good advice or paternal instruction is concerned. In consequence of these peculiarities, the unfortunate patient is known, if of the male sex, either as a "dude" or an "ass."

The other variety of the disorder in question, is *acquired*. It affects persons of moderate abilities who have been suddenly, through the influence of friends, raised to positions of eminence and responsibility. It is said that cases are frequently observed among railroad officials or custom house officers, and that they are occasionally met with in the Health Departments of our cities and states. The brains of the unhappy subjects of this sad complaint were formed and educated for the performance of quiet, unexciting labor in the small trades, and their possessors did well and respectably in such spheres of life. Being suddenly elevated through politics or similar influences, to posts of great responsibility for which they were in no wise fitted, their brain-cells were unequal to the strain, and various unhealthy forms of thought and action made their appearance. They began to act as if they were bosses, instead of servants of the public, and as if mere perfunctory performance of their duties rendered them sacred and above criticism.

The *prognosis* in this form is very un-

favorable, hopeless in the congenital variety, hopeless in the acquired variety, unless the patient quickly return to his former sphere and stay there.

Apart from this, all treatment is useless.

THE TREATMENT OF DIARRHŒA IN EARLY LIFE.

The activity of late years in the direction of foods for infants with digestive trouble is truly startling. The fact that certain bacteria cause stomach and intestinal troubles is fast becoming an accepted fact by all. The fact, also, that such bacteria may be introduced with the food which is principally milk, has been brought to our notice. Hence, of late, those having much to do with children have attempted to prevent these diseases by using sterilized milk.

Dr. Henry Dwight Chapin (*Medical Record*, June 21, 1890), thinks that while the excellent effects of sterilization have been noted by all, few have noticed the secondary effects of prolonged heat upon the ingredients of the milk. Prolonged heat affects principally the caseine, and for this reason he thinks it possible that sterilization may toughen the milk curds and make them indigestible. As an experiment, he tried the effect of various agents on human and cow's milk.

The only trouble with all such experiments seems to be that they rarely prove much, as it is almost impossible to imitate nature in digestion. Still, the idea is a good one and may lead to further investigation as to whether sterilization has not its drawbacks and whether

curdled milk free from bacteria is not worse than fresh milk, with its possible contamination.

Correspondence.

THE MUTUAL RELATIONS OF THE HEALTH DEPARTMENT AND THE MEDICAL PROFESSION.

DR. BLAKE'S REPLY.

Baltimore, July 3rd, 1890.

Editor Maryland Medical Journal:

DEAR SIR:—Dr. Rohé, in his communication published in your *JOURNAL* of June 28th, says that my article, published also in your issue of the 14th of June, calls for a few words of reply from him.

Now, had he replied to my paper, there would be no necessity for further comment by me. But I submit that his attempt to hide the real issue by giving my article what he calls a German and an American definition, will not answer the question, whether the Health Department is run in the interest of the public health or as a political machine.

Dr. Rohé says that inasmuch as the officials of the Department do not have the making of the laws, but their *execution*, much of my criticism is poppycock, and in the next paragraph he admits that he does not *execute* the laws, and consoles himself by the fact that what he does is not contrary to its spirit. He also admits that the law is old and made when the population of the city was only 200,000, yet my plea for a change in the laws to suit the present population and its needs is all poppycock, thus putting himself in the position of opposing the only method by which reforms can be introduced into that Department and the city saved from small-pox. Whether the Department makes the laws or not, it claims the credit of having had the last

contagious disease ordinance amended.

In regard to what Dr. Rohé is unkind enough to suggest as the cause of what he calls my animosity, etc., I will say that I did suggest to him that if the *personnel* of the Sanitary corps was not changed, I thought that it would be wise to retain a certain gentleman who had been an inspector for two years, besides having a fair educational qualification; also knowing that no charge had been brought against him, and knowing that the cause of his threatened displacement was a political one (a faction one at that), and being very well acquainted with the person who was prominently mentioned for his place, a gentleman who a short time before had retired from saloon keeping. I had no hesitation in saying that I thought the then inspector was the best qualified of the two.—Suffice it to say that the ex-saloon-keeper is an inspector to-day, but there is not the slightest animosity in the transaction, because I knew well enough the decree had gone forth and that my friend, Dr. Rohé, would have to abide by it.

When Dr. Rohé states that my charge of inefficiency, etc., on the part of the inspectors refers to a period six or eight years back, he is mistaken, and certainly he has not read the recent communication to your JOURNAL on this point, or he could not thus conclude.

As to my waxing humorous over the minor avocation, etc., of the Sanitary Corps, I would say that there was no intention on my part to do so. I do think, however, that the Sanitary Officers should have some previous training before they enter upon so important a duty as inspectors, and thus follow the illustrious examples of Abraham Lincoln, Andrew Johnson and James A. Garfield in thoroughly preparing themselves by hard and constant study for the responsible positions to which they were afterward elevated.

Referring to the closing remarks of Dr. Rohé as to the chance for some one else to become Health Commissioner, I might

say that upon the theory that few officers die and none resign, that that kind of talk is nothing more or less than poppycock.

Yours respectfully,
JOHN D. BLAKE, M. D.
602 South Paca Street.

IN DEFENSE OF THE HEALTH DEPARTMENT.

Editor Maryland Medical Journal:

DEAR SIR:—Prompted by a simple sense of justice, I cannot refrain from expressing my humble protest against the recent abuse of the Health Department and its Commissioners, for failing to carry out certain suggestions of the proposers, which do not exist in law. The Commissioner can only recognize the law as he finds it on assuming the office, and if he carries this out to the best of his ability, it is all we can demand of him. Until we can get a better system, would it not be wiser in us to lend him all the sympathy and support we can, in enforcing the one now on the statute book?

The present incumbent, even by the admission of his critics, is the right man in the right place, and I feel assured that no one will be more ready to consider and act upon any derelictions of duty by his subordinates, when brought to his notice, than he will. Of these latter gentlemen I have nothing to complain, as in the cases when I notified the Department of the existence of infectious disease, they acted promptly and to the satisfaction of myself and the parents.

Yours Respectfully
JOHN R. QUINAN, M. D.
1367 North Gilmor Street.

Reviews, Books and Pamphlets.

A Treatise on Neuralgia. By E. P. HURD, M. D. Detroit: George S. Davis, 1890. Pp. 153. Price, cloth, 50 cts., paper, 25 cts.

A book on a symptom must necessarily cover much ground, and is not often satisfactory to author or reader. This work gives an account of almost every variety of pain, with abundant references to authorities. The hopelessness of treatment is shown in the large number of drugs as recommended in the appendix. The author deserves credit for the courage to attack such a diffuse subject.

On the Comparative Physiological Effects of Certain Members of the Ethylic Alcohol Series (CH_4O to $C_5H_{12}O$), on the Isolated Mammalian Heart. By JOHN C. HEMMETER, M. D., Candid Philos. Johns Hopkins University. Reprinted from *Studies from the Biological Laboratory of the Johns Hopkins University*, Vol. IV, No. 5.

Recent Experiments on the Physiological Activity of Ethylic Alcohol. By JOHN C. HEMMETER, M. D., Candid Philos. Johns Hopkins University. Reprinted from *Transactions of the Medical and Chirurgical Faculty of the State of Maryland*. 1889.

Cystic Tumor of the Conjunctiva Produced by Striking the Eye with Bristles of a Hair Brush. By S. LATIMER PHILLIPS, M. D., Savannah, Ga. Reprint from *Atlanta Medical and Surgical Journal*.

Miscellany.

REPORT OF THE STATE BOARD OF HEALTH.

At a quarterly meeting of the State Board of Health, held last Monday, Dr. Charles W. Chancellor, the secretary, submitted an interesting report, in which he said: Throughout the entire state there has been, during the quarter just ended, an unusual degree of good health. In some communities measles have been quite prevalent, but, so far as our records, collected under the act of Assembly, chapter 622, approved April 8th, 1890, show, the mortality from this disease has been exceptionally small. Diphtheria, typhoid fever, scarlet fever, diarrhoeal and dysenteric disorders have been less prevalent than during previous years. The Cum-

berland epidemic, which at one time threatened to assume considerable proportions, has been arrested, and the town now offers a safe retreat for persons seeking a summer home. Upon these facts the people of the state are to be congratulated. With proper attention to the rules of healthful living and the ordinary laws of sanitation, there is no reason why Maryland, from the Atlantic to the Alleghanies, should not maintain the high standing to which her soil, climate and situation entitle her, as one of the most healthful and delightful states in the Union.

In the city of Baltimore, with its exceptionally low death-rate, there has been the usual increased mortality at this season among children under five years of age, owing, no doubt, in a great measure to improper food, or, more properly speaking, to adulterated and impure milk. But the fact must not be lost sight of that an impure atmosphere is an important factor in determining the prevalence of infant mortality. Undoubtedly, the method at present in use for the disposal of excretal filth in this city is fraught with danger to the future health of the community, and in the event of the introduction of infectious disease may imperil not only the lives of our own people, but also the health of the surrounding country.

Dr. Chancellor then spoke of the efforts of the Board, through the distribution of circulars, to secure the prompt mortality returns of contagious and infectious diseases, the need of special sanitary officers in every county, and of a hygienic laboratory in connection with the inspection of foods and drinks, where local health officers could obtain the information they desire.

THE MANUFACTURE AND SALE OF PATENT MEDICINES.

The compounding of patent medicines has increased year by year, and has become one of the most lucrative trades, and one found to be liable to numerous abuses. While the evil cannot be altogether stopped, it would be well if some

steps could be taken to secure the passage of a law for the licensing of such medicine, in order to control the sale of the same, as in the case of spirits, for such medicines are in no way necessities of daily life to the people; as vended among us there is certainly need for sanitary restrictions. I would suggest, therefore, that the Board take steps at once to secure the co-operation of the medical profession of the State in preparing for the presentation to the next General Assembly the draft of a law providing for statistical returns, to be made semi-annually, respecting the number and kind of patent medicines sold in this state, and for imposing a "high license" upon all manufacturers, dealers, and traveling pedlers selling such medicines.

FOOD AND DRINK INSPECTION.

After expressing regret at the failure of the Medical Act, the original efforts of which were made by the Board, Dr. Chancellor spoke at length on the organization of the department of food and drink inspection. Of milk he says:

Investigations made during the last month by the Board's analyst, have established the fact that while much of the milk shipped from country farms or dairies outside the city is practically pure and fully up to the required standard in solids and specific gravity, a large per centum of that sold by the city dealers is adulterated or so treated as to increase its bulk and proportionately lessen its nutritive qualities.

Since beginning the inspection in this state about six weeks ago, several dairies in Baltimore which were found to be selling impure milk, have closed up their establishments to avoid prosecution, and a general improvement in the quality of the milk sold has already been observed.

ADULTERATION OF WINE AND SPIRITS.

The wines and spirits which have been inspected under the authority of the Food

and Drink Act are principally such as are sold for medicinal purposes, and the examination, therefore, has been made with reference to their use as drugs as well as beverages, hence the United States Pharmacopœia of 1880 has been followed as the standard of requirement. All the supplies of whiskey thus far examined have been found to be adulterated, while not a few of the American wines do not conform to the required standard. The terms "whiskey" and "brandy" seem to be no longer applicable to spirits distilled from grain and mellowed only by time or produced by the fermentation of grapes, but to adulterated compounds that have been submitted to the process of mixers, blenders and other so-called "improvers," until they are lamentably deficient in the requirements of every standard of purity. Indeed it would seem to be quite impossible, at present, to get a pure article of either whiskey or brandy. The mere fact of "coming out of bond," or "straight through" the Custom House, is generally accepted as sufficient evidence that they are pure and genuine, but this is a delusion, as they are often flavored, colored, and branded or labeled to meet the tastes of American connoisseurs. When such "stuff" is recommended for the sick, the aged and debilitated, or as a beverage for invalids convalescing from disease, a more insidious fraud can scarcely be imagined.

SOPHISTICATED BEER.

The act to prevent and punish the adulteration of food and drinks passed by the last legislature, in addition to the penalties imposed, authorizes the Board to "publicly expose any adulteration or corruption of articles offered for sale as food or drink, &c." Under this provision beer, ale and compounded spirits will be treated when found to be adulterated or corrupted. Lager beer, well made of malt or hops, is a pure and good beverage, possessing slightly exhilarating qualities, and might well take the place of whiskey with those who indulge in the

use of ardent spirits, and who might be won from a growing taste for strong drink; but adulterated as it often is, with drugs, to save hops, it produces headache, nervous prostration, and is otherwise injurious to the system. The use of coccus Indicus, tobacco, Indian hemp, or what not, is to be especially deprecated, for such substances impart intoxicating rather than stimulating qualities to malt liquors, and produce the lowest kind of inebriety, closely allied to insanity. The opinion has been expressed that many cases of brutal and purposeless violence, which are often recorded of those who drink beer to excess, are referable to the maddening influence of such ingredients. Much time and attention will, therefore, be devoted to this particular line of adulteration, in order to ferret out the "crookedness" of dishonest and unscrupulous manufacturers, if any such are to be found in this state.

UNSOND FISH AND FRUITS.

My attention having been called to the fact that large quantities of fish that had been inspected and condemned in the Eastern markets were shipped and sold in this market, a competent inspector, Mr. John Streckfus, was appointed, with authority "to inspect any diseased, corrupted or unwholesome provisions offered or exposed for sale in the markets or adjacent thereto, and issue notices to prevent the sale of such articles of food." Under these instructions the inspector has condemned and destroyed a large quantity of spoiled fish, fruits, vegetables, etc., amounting in the aggregate to twelve or fifteen tons. In this particular the City Health Department and the large dealers in fish have offered valuable assistance.

A meat and market inspector, J. Robert Godman, has also been temporarily appointed, with like powers to condemn diseased, unsound, or corrupted meats, fowls, vegetables, etc., and to keep watch over the manufacture of sausages, lard, etc., especially with reference to preventing the use of impure substances

in the preparation of such widely used articles of food.

As a résumé of the analytical and other work done to date, 100 per cent. of the whiskey examined, 83½ per cent. of the wine, and 38½ per cent. of the milk, have been found adulterated. Of solid matter, 45 lots of fish, 17 lots of meat, 15 lots of bananas, 18 lots of pine-apples, 4 lots of oranges and one lot of apples, aggregating about fifteen tons, have been condemned and destroyed.

A NEW KIND OF CIRCUMCISION.

During the discussion of an address by Dr. Joseph Hoffman before the Alumni Association of the Medical Department of the Niagara University, at Buffalo, recently, it was suggested by Dr. Wilder, of Ithaca, that, in view of the dangers to which human beings are exposed from inflammation of the vermicular appendix, it be extirpated by aseptic laparotomy soon after the birth of the child.—*Med. Record.*

THE LABORATORY PRIZES (SERIES OF 1890), \$400 FOR BIOLOGICAL RESEARCH.

In the hope of adding to our present knowledge of the causes of failing nutrition in aging organisms, the undersigned hereby offers three cash prizes of \$175, \$125 and \$100 for the best three comparative demonstrations, by means of microscopical slides, of the blood capillaries in young and in aged tissues, canine or human.

By young tissues (canine), are meant tissues from animals not less than twelve years of age.

By young tissues (human), are meant tissues from subjects between the ages of ten and twenty years.

By aged tissues (human), are meant tissues from subjects not less than sixty-five years of age.

While a preference will be given to demonstrations from human tissues, it will be possible for work in canine tissues to take the first, and, indeed, all of the

prizes. But of two slides equally well done in all respects, one canine the other human, the latter will be given the preference. Canine tissues should be from large animals.

Twelve slides from young and twelve from aged tissues must be submitted by each competitor, together with a full description of the subjects, methods pursued and every detail and circumstance which is likely to throw light upon, or account for any peculiarity. The slides are for comparison as to the condition of capillary circulation, the young with the old, and should be in numbered pairs, or groups from the same kind of tissue. The term tissue is used in general sense, e. g., pulmonary tissue, hepatic tissue, renal tissue, osseous tissue, muscular tissue, nerve tissue, alimentary tissue, etc.

No particular schedule of methods for injection, staining or mounting will be insisted upon, and no more definite directions, or explanation will be given.

The slides carefully packed and boxed, together with descriptive manuscript, can be sent by mail.

It is stipulated that the demonstrations which receive the prizes, shall become the property of the subscriber, for publication with the name of the competitor. All others will be returned, if desired.

Pseudonyms will not be required. Accompany slides in every case, with (real), name and address. Unless of known reputation as a biologist, a reference is respectfully solicited from competitors.

Reservation: no award will be made unless work of at least ordinary merit is submitted.

This offer is made on the first day of January, 1890, and will remain open until the twentieth day of August, 1890.

Slides and manuscript will be examined and receipted for as soon as received.

The prizes will be adjudged on the first day of October, 1890.

These nominal prizes are offered less in expectation of results from the money as an agent, than in hope that the offer may furnish a *point d'appui* for really needed work.

The capillaries of the blood circulatory or vascular system are a growth from distinctly differentiated protoplasm which passes through a well-marked cycle of development and decline, in the midst of and associated with other tissues of the animal organism. Nutrition, oxygenation and the removal of waste are contingent upon their well-being.

As the organism ages and encounters the wear and tear of life, the capillaries even more than other tissues, suffer detriment. The nuclei of their coats shrink and perish and the minute tubules, themselves, become blocked up, obliterated and are absorbed. Where the nuclei have perished no renewal, or renovation can take place. So far does this deterioration and obliteration sometimes extend, that it becomes an interesting question, how far the decline of other tissues is accelerated by it.

To gain light on this point and ascertain the condition of the capillaries in age as compared with adolescence, the Laboratory prizes are offered this year, for research in this direction, as a part of a general investigation of the causes of old-aging and organic death.

Address C. A. Stephens' Laboratory,
Norway Lake, Maine.

A SIMPLIFIED METHOD OF DISCOVERING KOCH'S BACILLUS IN THE SPUTUM.

The difficulties experienced with the present methods of staining the tubercle bacilli, both in the amount of time required and the proper degree of heat and coloring to be used, have led Dr. E. Dineur to propose a method which in his hands has yielded excellent results. He places a few drops of the sputum upon a watch glass, adds 2 or 3 drops of a concentrated alcoholic solution of fuchsin, and then by means of a glass rod a drop of carbolic glycerine (25 parts of carbolic acid and 100 parts of glycerine); the mass is then well stirred. The mixture is then exposed for a few minutes to a temperature of 80° to 100° C., the sputum becoming appreciably thickened

thereby. By means of a needle a portion as large as a pin's head is placed upon the slide, together with a drop of pure or diluted (1-1) glycerine, and the cover glass is then applied. At the edge of the latter he places a drop of diluted (1-5) sulphuric acid, watching through a microscope the effect produced upon the preparation. "The various morphological substances, the white blood corpuscles, epithelial cells and bacteria gradually grow pale and disappear; the bacillus alone persists a sufficiently long time and appears stained a beautiful red upon a colorless field." In this method as in the usual ones, the author employs the Abbé condenser.—*Cent. für Bak. und Parasitenkunde*.—*Journal of A. M. A.*

THE PNEUMONIA OF DRUNKARDS.

In that dangerous form of pneumonia which occurs in drunkards, *pneumonia potatorum*, George T. Welch, of Passaic, N. J. (*Med. Record*), recommends hourly doses of chloral, fifteen grains, and infusion of digitalis, half an ounce. In a case described this was was repeated for twelve hours. These cases are very apt to die under ordinary treatment, as all practitioners know; but Dr. Welch says that, throwing aside all other means, he has scored success with the combination he so confidently recommends.—*Times and Register*.

A NEW SIGN OF PERICARDITIS.

The diagnosis of a pericardial effusion in some cases is extiemely difficult, and a symptom, first noted by Bamberger, is said to be a constant one and a material aid in correct diagnosis. E. Pins describes again (*Wiener Med. Wochens.*) this sign. On percussing the patient in a sitting position, over the left back, the percussion sound will be dull, tympanitic, or wholly hollow from the angle of the scapula downward. This hollow percussion sound extends downwards into the splenic dulness and laterally to the axillary line, when it either changes into

the full percussion sound of the lungs or joins the dulness of the heart. This dulness is heard best over an area as large as a crown piece, which extends about three fingers' breadth from the angle of the scapula. On auscultation at this point where dulness is most marked, bronchial breathing, increased vocal fremitus, and in the centre of the dulness distinct bronchophony can all be discovered. No friction sound can be distinguished in the area of dulness. If the patient bend forward, after a few minutes, the above-mentioned percussion sounds will have changed considerably. The dulness does not reach up to the angle of the scapula but at the area of the former dulness, about three fingers breadth below the scapula, there is full resonance. At the point of the former absolute dulness the percussion sound is tympanitic, and the bronchial breathing has wholly or partially disappeared. The same changes in percussion and auscultation, although less definite, take place if the patient is placed on his left side. The changes are also very characteristic in the knee-elbow position, if the dyspnœa will allow it to be assumed. After a few minutes in this position, the dulness, up to a small line at the periphery of the lung below, will have nearly all disappeared. Where bronchial breathing was heard crackling sounds are present, but disappear after a few respirations, giving place to normal vesicular breathing. When the pericarditis has existed several days these phenomena are not present. They disappear with the amelioration of the subjective symptoms. They last from three to six or more days, according as the case is acute or not. Dr. Pins ascribes these new physical signs to a backward displacement of the heart, producing a compression of the lower lobe of the left lung, and are chiefly found in young adults of slender build, in whom the chest is flattened antero-posteriorly. This condition is distinguished from pneumonia or pleurisy by the changes in the physical signs when the patient assumes a new position.—*Mitth. d. Wien. Med. Doct.-Coll.*—*Satellite*.—*Canada Med. Rec.*

ARSENICAL POISONING.

The possibility of absorption when preparations of arsenic are employed externally has long been recognized, and frequent warnings have been given against its use as a caustic, and against the opposite evils of over-timidity and undue temerity; the former leads probably to the use of dilute preparations of insufficient strength to act as a caustic and produce a slough; the latter may result in its application over a large area, when, even though a slough may form and, in part, protect the denuded surface, the action is likely to be imperfect, and a proportion of the arsenic may be absorbed and produce toxic effects. In a case which led to an inquest recently in Ireland the report does not give sufficient details to allow of any definite statement being made upon the strength of the preparation employed. A certain Mrs. Warren, who is known as the "Cancer Curer," had treated a woman for cancer of the breast with a fatal result. The analyst who examined the stomach and breast of the deceased was of the opinion that death was caused by arsenic contained in a plaster placed on the breast. There was no doubt that the poison was absorbed from the plaster, and that there was sufficient to cause death. The most curious feature of the case is that the foreman of the jury and another juror spoke on behalf of Mrs. Warren, and that, although a verdict of manslaughter against her was returned, a rider was appended in her favour, the foreman remarking that but for her a great many people would be in their graves. It does not appear that the "Cancer Curer" possessed any qualifications, or that she had received any training. As a secret "cure" for cancer, arsenic has long been used; its indiscriminate employment, however, is attended with considerable risks.—*Lancet*.

THE TREATMENT OF DROPSY OF CARDIAC ORIGIN WITH CALOMEL.

A few years ago the diuretic properties of calomel attracted a great deal of atten-

tion, but it seems since 1886-'7 to have been entirely neglected, perhaps on account of the great number of new remedies which have called for investigation. Its properties as a diuretic, however, are again emphasized in the report of three cases of cardiac lesion by Dr. E. G. Garvene (*Therapeutische Monatshefte*, April, 1890), resulting in severe dropsy, in which the use of calomel produced the most striking relief. In these three cases digitalis, caffeine, and strophanthus had been used, and almost without effect. Calomel was, therefore, substituted in doses usually $1\frac{1}{2}$ grains every two hours, with an almost immediate increase in the diuresis. In some cases slight diarrhoea was produced, but no symptoms of stomatitis occurred, perhaps through the regular employment of gargles of potassium chlorate and brushing of the gums with tincture of myrrh.

—*Therapeutic Gazette*.

EXTRACT OF CANNABIS INDICA.

Dr. Cripps Lawrence warns prescribers to be careful regarding the use of this extract, which is well known to be of exceedingly variable activity, owing to the crude drug being sometimes inert and sometimes active. He mentions that five years ago Messrs. Squire and Sons informed him that from the time Dr. O'Shaughnessy first introduced cannabis indica into England, and gave some to the late Mr. Peter Squire in order to make it into an extract, up to the present day, they have been continuously supplied by the original collectors of the plant, and each sample has proved good, yielding efficient preparations; but they have found that the active principles vary in different specimens of the plant from year to year, so that they cannot predicate the actual degree of potency to be attributed to an extract or tincture prepared under identical conditions, until the preparation has been adequately tested for any given year. In this connection we may recall the advice of Dr. George Watt contained in a communication to the *Chemist and Druggist* (Feb. 19th, 1887), in which he recommends

"chemists desirous of making the very best extracts of Indian hemp to pay the full price for Bengal 'Ganja,' and to import the article from Calcutta instead of from Bombay. when there would be every chance that the defects complained of in the extract as now prepared, would disappear completely." The reason of this recommendation is that the greatest care is taken in Bengal to insure that the female plants are not fertilized by the male, so that the full narcotic power of the drug may be retained. This it loses after fertilization.—*Chem. and Drugg.*

—*American Druggist.*

TERPIN HYDRATE IN WHOOPING COUGH.

Dr. Manasse recommends in the *Therapeutische Monatshefte*, the use of terpin hydrate as a remedy for whooping cough. He used it with success in forty-one cases, giving it to young children even under a year old, in daily doses of 22 grains; the average dose in powder form was 7 to 15 grains three times a day. He claims to have observed, after four or five days of the treatment, a distinct decrease in the number and intensity of the attacks.

—*Medical Summary.*

FOR WORMS.

The following is said to be a specific for ascaris lumbricoides:

R.	Santonine	gr. x
	Irisin	gr. ij
	Saccharum lactis	gr. iv

M. Sig.—One powder every night at bed time. This for children from 3 to 4 years of age.—*Medical Summary.*

INFLAMMATORY LEUCOCYTOSIS.

Von Limbeck's investigations, brought forward at the Heidelberg Congress last year, have shown that the white corpuscles of the blood, physiologically increased in number during digestion, are considerably increased in number in all acute diseases which are accompanied by coagulating exudations—for example, lobar

pneumonia and suppurative peritonitis. This increase does not occur in the infectious diseases which give rise to no exudations into the tissues—for example, typhoid fever, intermittent fever, septic fever, even if the temperature rises very high. The danger of this inflammatory leucocytosis is mostly proportioned to the desire of exudation and its richness in cells; it declines critically with defervescence; it does not occur with stationary exudations, and it is not diagnostically, but prognostically, a valuable criterion. In a discussion on this subject at Prague, von Jacksch confirmed the statements of von Limbeck as regards typhoid and lobar pneumonia in children, the proportion of white to red corpuscles being 1: 40 to 75. In the latter disease, the haemoglobin amount was also distinctly lessened.

—*British Medical Journal.*

IODOFORM AND BORIC ACID SNUFF.

R.	Iodoform, boric acid, of each	
	in fine powder	gr. ix
	Subnitrate of bismuth	gr. ix
	Powdered elm bark	5 iss

Mix and use as a snuff for nasal catarrh.

—*Medical Summary.*

MENTHOL IN THE HYPEREMESIS OF PREGNANCY.

Hyperemesis in pregnancy is a grave complication. Within the last ten years Professor Horwitz, of St. Petersburg, and Dr. Graily Hewitt have written upon the subject. Dr. Copeman first published in the Journal of May 29th, 1875, the famous case which he treated after the method to which his name has since been applied. "Copeman's treatment" signifies the relief of sickness by dilatation of the os and cervix uteri. The obstetrician's fingers are usually sufficient for the purpose. The treatment has been widely adopted; between 1875 and 1880 several experienced obstetricians contributed papers to our columns on successful cases, and for full information we refer the reader to the statistical tables published by Dr. Hewitt in

the *Transactions of the Obstetrical Society* for 1884. Of course Copeman's treatment does not suit every case. Dr. Gottschalk recently described a case in the *Berliner klin. Wochenschrift*, where in a woman, aged 26, who had been pregnant three times, uncontrollable vomiting set in during the second month of her fourth pregnancy. Neither cocaine nor Copeman's treatment availed, and the sickness continued until abortion was induced. The patient became pregnant for the fifth time, and the vomiting returned, haematemesis taking place. A draught consisting of menthol 1 part, rectified spirits 20 parts, and distilled water 150 parts was prescribed by Dr. Gottschalk, and a tablespoonful given every hour. The vomiting ceased after the third dose, and pregnancy proceeded to term without any further complications. A second case was successfully treated with menthol.

—*British Medical Journal.*

IMPOTENCY.

A reliable remedy:

R <small>y</small>	Tinct. sanguinariæ	f $\frac{2}{3}$ j
	Ext. stillingiæ	f $\frac{2}{3}$ j
	Celerina (Rio)	f $\frac{2}{3}$ vi

M. Sig.—Teaspoonful four times a day.

—*Medical Summary.*

Medical Items.

Italy is prosecuting quacks and illegal practitioners.

The MARYLAND MEDICAL JOURNAL may be seen at the reading rooms of the Tenth International Medical Congress.

An actress in a Berlin theatre was found dead in bed, the result of tight lacing.

Nussbaum the Bavarian Surgeon, has resigned from his professorship at the University of Munich, on the plea of ill health.

By the burning of a livery stable on Eutaw Street last week, Dr. T. A. Ashby lost his horse, carriage, and harness, and Dr. G. Lane Taneyhill, his carriage.

Dr. and Mrs. George H. Rohé having sufficiently recovered from their late driving accident, have gone to Narragansett, Nantucket, and Newport for a short trip of recreation.

An eccentric woman of Boston, after making several charitable bequests to hospitals, has left her body to the Massachusetts General Hospital for dissection.

As noticed in these columns six weeks ago, Dr. I. Minis Hays has resigned his position as editor of the *American Journal of the Medical Sciences*, and Dr. Edward P. Davis succeeds him.

Exchanges and other journals have said some very kind words about the MARYLAND MEDICAL JOURNAL since it increased its size and improved its appearance. Such praise is thankfully received and gratefully acknowledged.

A committee has been formed at the Sorbonne for encouraging foreigners to study at the University of Paris. M. Pasteur is president. It is proposed to give special facilities to foreign students immediately upon their arrival in Paris.

The Maryland Homœopathic Free Dispensary and Hospital was opened last Monday at 323 North Paca Street, under the auspices of the Maryland State Homœopathic Medical Society. The medical school will probably be opened in October 1891, and the faculty will be elected by that time.

The editor of *The Writer*, the Boston magazine for literary workers, is preparing for early publication a "Directory of American Writers, Editors, and Publishers," in which he wishes to include the name and address of every writer who has had a book printed with-

in ten years, or an article in any periodical of national circulation within five years. There is no charge of any kind connected with the work. Full information will be sent, on request, by the editor of *The Writer*, P. O. Box 1905. Boston, Mass.

Germany has 18,467 doctors, and thinks the number is too large; especially as the death rate in the profession is less than 2 per cent. The smallest proportion is in Wurtemberg, which has one doctor to 2,950 inhabitants.

A Michigan magnetic healer has received an appointment of one year in an institution supported by the county, for unlawful use of the mails. A contemporary says his duties are those of "geologist extraordinary."

Gaillard's Medical Journal says: What a commentary upon "ignorance in high places" is offered by the Governor of Maryland refusing to sign the Bill for raising the standard of medical education in that State.

The fee allowed in Great Britain to medical witnesses in courts of law is one guinea for every day's attendance at trials in the supreme and county courts, with traveling expenses. In the lower or police magistrate courts the fee is half a guinea.

In London, Gospel missions are given from time to time to medical students, and inducements in the way of abundant, if not particularly rich or dainty, refreshments are held out to them to attend the services.

A French policeman arrested three prisoners, and not having the handcuffs to secure them he cut off their suspender buttons. By this means their hands were completely occupied and they could not run away, so they were safely marched to prison.

A prize of \$300 has been awarded to Dr. H. A. Hare and Dr. Edward Martin, of Philadelphia, under the Fiske Fund of the Rhode Island Medical Society, for an essay on the treatment of wounds and obstruction of the intestines. The subject that will be open for competition for the prize of 1891 is disease of the hip joint.

The Archduchess Marie Valerie, of Austria, has handed over the sum of 50,000 florins, voted by the Vienna Town Council for public charitable purposes on the occasion of her wedding, to the St. Anna Children's Hospital, on condition that it shall be applied to the erection of a pavilion for children suffering from infectious diseases.

The Maine Medical Association held its annual meeting in Portland, on June 10th, 11th, and 12th. The following officers were elected: President, Dr. S. B. Hunter, of Machias; First Vice-President, Dr. B. B. Foster, of Portland; Second Vice-President, Dr. F. L. Dixon, of Lewiston; Corresponding Secretary, Dr. O. W. Stone, of Camden.

It is proposed to establish a Medicolegal Institute in the centre of Paris. Many *post-mortem* examinations, which at present have to be performed at the Morgue, will then be made in the new institution, and it is hoped that this arrangement will enable the practical teaching of forensic medicine to be carried out without wounding the feelings of the relatives of the deceased persons.

The Delaware State Medical Society began its second century on June 13th, at its 101st annual meeting in Wilmington. The election of officers resulted in the choice of the following: President, Dr. Joshua A. Ellegood, of Laurel, Sussex county; Vice-President, Dr. Ezekiel Cooper, of Camden, Kent county; Secretary, Dr. W. C. Pierce, of Wilmington; Treasurer, Dr. Joseph H. Chandler, of Centreville.

MARYLAND MEDICAL JOURNAL,

VOL. XXIII. No. 11. BALTIMORE, JULY 12, 1890.

NO. 485

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Original Articles.

GRANULAR SUPPURATION OF THE MIDDLE EAR.*

BY HIRAM WOODS M. D., OF BALTIMORE.

Assistant Surgeon at the Presbyterian Eye, Ear, and Throat Charity Hospital.

The subject to which I ask the attention of the Society to-night, certainly does not possess the charm of novelty. The large majority of chronic ear discharges is granular, and the frequency of otorrhœa, every physician well knows. It falls to my lot to treat a large number of these cases. The importance of making as exact a diagnosis as possible of the condition of the discharging ear, and of varying treatment in accordance with the diagnosis, impresses itself upon me

more forcibly as my experience enlarges. An "otorrhœa" is to be regarded as a symptom of one or more of several underlying pathological conditions. The failure to cure often lies in an incomplete diagnosis. On the other hand, there are cases in which a thorough diagnosis only reveals the impossibility of therapeutic agents ever effecting a cure. Such cases I think are rare.

In the recent edition of his "Manual of Diseases of the Ear," Dr. Albert H. Buck, of New York, divides chronic suppurative otitis into three classes. Neither his nor any one's division can be absolutely correct. One form of suppurative otitis imperceptibly assumes the characteristics of another, and several causes may work simultaneously. For purposes of study, however, Dr. Buck's classification seems adequate. 1. The uncomplicated suppuration of the tympanum, 2. that due to the presence of granulation tissue, 3. that due to the presence of diseased bones,

*Read before the Medical and Surgical Society of Baltimore, April 10, 1890.

The uncomplicated cases are few. They are those patients who, having once had an attack of acute aural catarrh followed by discharge,—(in common parlance, who have had an ear-ache, finally "cured" by the appearance of "matter")—continue to have an occasional or possibly constant discharge from the ear, which is neither irritating nor offensive. So far as the patient knows, the hearing is unaffected, although it seldom reaches the normal standard when tested. There is a perforation in the drumhead through which a little matter oozes or can be blown by Politzerization. A clean, healthy mucous membrane may be seen through the perforation. Almost any mild astringent will put a stop to such an otorrhœa, but it is apt to return unless the perforation can be healed. Such patients usually learn how to keep the ear clean by syringing, and get on comfortably. Personally I have never seen more than two or three cases of this kind.

The influence of necrosis of the bony wall of the tympanum in keeping up an otorrhœa is the same as that manifested by dead bone at the bottom of a sinus in any other part of the body. When the necrotic area is small and confined to the tympanum, the case is usually obstinate; more can be done in mastoid necrosis.

This leaves us Buck's second class, granular suppuration, the most numerous of the three. The lesion in this kind of suppuration is the formation in the tympanic mucous membrane of little masses, which are made up of ordinary granulation or connective tissue. Occasionally they show a mucous structure.

By examination with the head-mirror and speculum, this granulation tissue sometimes appears as little bead-like elevations on the inner wall of the tympanum, seen through the perforation in the tympanic membrane. Again, this tissue stands out from the point of its growth as a projecting mass, the size of a pea. Still again it may take on rapid growth, and project into the canal, forming an aural polypus. From its commencement, however, to its attaining large size, its structure is one and the same.

It may start from any point in the tympanic cavity, and after the discharge has caused ulcerations in the wall of the canal, granulations may also spring from the external ear. How is this proliferative tendency of the tympanic mucosa to be accounted for? Buck mentions two sources of irritation which can produce it: 1. The presence of the discharge after an attack of acute otitis media. If the ear is kept clean, i. e. if proper treatment is instituted at the start, the discharge will usually cease. If neglected, however, it settles in the crevices of the tympanum, decomposes, and becomes a powerful irritant. Proliferation of the mucous membrane naturally follows.

A second cause is necrosis of the long tympanic wall. This may result from either direct extension of the inflammation to the periosteum, with subsequent denuding of the bone, or the presence in the tympanic cavity of hard masses of pus, which may destroy the mucous membrane and periosteum by pressure. Neglect and uncleanliness are the first of the train of causes leading to necrosis. How readily and persistently polypi spring up at the mouth of a sinus leading to dead bone is a matter of common observation. The presence of a small necrotic area in the tympanum is frequently indicated by the rapid return of polypi after removal. It is thus seen that granulations form in the tympanum as a result of neglected suppuration, and, in turn, perpetuate the discharge because the formation of pus is a necessary accompaniment of their growth.

The discharge in cases of granular suppuration is more or less characteristic. It is offensive, thick, and abundant. It is sometimes tinged with blood. Bleeding often follows the gentlest manipulations. Ulcerations are found along the wall of the canal, and vesicular and pustular eczema of the auricle is not uncommonly seen. The ear often retains a surprising amount of hearing power; the explanation of which is that the stapes is not prevented by the granulations from moving in the oval window of

the inner tympanic wall. When the granulating process has tied down and made immovable this ossicle, deafness is pronounced.

This review of the pathology of granular suppurative otitis leaves no doubt about the treatment to be employed. The best thing to do is not to allow the patient to get granular suppuration. Proper attention to acute otitis media will usually accomplish this. The ear must be kept clean. The syringe, angular forceps, curette, Politzerization, careful wiping with absorbent cotton—these are the chief means of cleansing the ear. Often this cleaning is the only treatment acute otitis media requires.

But if the disease is granular at the time we first see it, prophylaxis is out of the question. Our problem then is, how to get rid of the granulations. In what I have to say upon this, I shall follow what has seemed to me to give the best results. For nearly all of the therapeutic measures advised, I am indebted to the works of Politzer, Roosa, and Buck.

The ear having been cleansed of pus either by wiping it away with absorbent cotton on a probe, or by syringing and subsequent drying, a careful examination should be made through an ear speculum with reflected light.

The points to notice are the condition of the canal, the size of the perforation in the drum membrane, and the condition of the mucous membrane, if this structure can be seen. Careful search should be made for pieces of hardened pus in the tympanum. While these may escape syringing or wiping, the angular forceps or Buck's curette will bring them away. If they do not come easily, they should be softened with a bicarbonate of soda solution, or per-oxide of hydrogen.

In a number of cases a large perforation will be found, and the little glistening points on the back of the cavity will come clearly into view. Powdered boracic acid will often dry up these granulations and cause them to disappear. If the powder is saturated with the discharge

after 24 hours, the ear should be again cleansed, and a second application made. If it is saturated after a second or third packing, I think it is best to abandon the dry treatment, and have recourse to other remedies. A saturated solution of boracic acid, or a 1-4000 or 1-5000 corrosive sublimate solution may be used instead of the powder. Fluid applications are specially serviceable in small perforations.

Buck suggests a very simple way of forcing remedies through a small perforation in the tympanic membrane. I have repeatedly had patients taste the remedy in the pharynx after the manipulation. The head is inclined so as to bring the diseased ear upwards. The canal is filled with the fluid. Firm pressure is then made upon the fluid in the canal by forcing the tragus backward and inward so as to close the meatus. This can best be done by pulling the auricle back at the same time that the tragus is pushed against the meatus. While the pressure is maintained, the auricle should be released. Still exercising pressure upon the tragus, have the patient swallow. In most cases the fluid will pass into the tympanic cavity unless the Eustachian is closed.

If the antiseptic powders or solutions mentioned fail to arrest or lessen the discharge in a few days, I resort to astringents or to alcohol. Syringing is the method of cleaning the ear. When I can see the patient either daily or every other day, I usually apply myself a 30 grain solution of nitrate of silver, or the tincture of iron. Between visits, home treatment is confined to syringing, a proceeding in which the patient's parent or nurse should always be given an object lesson. If home treatment is to be relied upon, frequent syringing and instillation of alcohol are the means employed.

The granulations are not always the pin-point affairs just noticed. They are often as large as peas, and keep up suppuration indefinitely. My own observation coincides with Buck's statement that medicinal agents have little or no effect upon granulations of this size.

Mechanical removal is necessary. The polypus snare is the means usually advised. When these granulations or polypi are quite large, it is easy to remove them with the snare. Small ones cannot be easily ensnared. Buck's curette, which the inventor offers as an efficient help in cleaning the ear, has often enabled me to completely remove these small growths and so stop the discharge. Dr. Buck does not offer his curette as a scraping instrument, and rather disapproves of its being made with a sharp edge. Even with its dull edge, it is the most useful instrument I know of for getting rid of small granulations. The granular tissue should always be removed even with the level of surrounding healthy tissue. For some time I have been in the habit of touching the point of origin of a polypus with carbolic acid, after removing the growth. In a few instances I have used chromic acid, and have never seen any bad effects from it. As a rule, however, it is too powerful an escharotic to use in the ear. Dr. Buck prefers nitric acid to either of the above. The growth is less apt to return after removal, when one of these agents is used. If the discharge persists when all the polypi visible have been removed, the probable cause is either the presence of some undiscovered polypi, or else dead bone. In the latter case, as previously mentioned, the growth will probably return as fast as it is removed.

525 North Howard Street.

Infant mortality has reached quite an appalling figure at Martinengo, in Upper Italy, owing to the prevalence, for more than a month, of an epidemic having much in common with measles. The physicians who have visited the place from Bergamo and other leading towns, are not yet satisfied as to the nature of the disease, and are at present examining it preparatory to issuing their report,

ONE HUNDRED CONSECUTIVE CASES OF LABOR AT THE MARYLAND MATERNITÉ, WITH A DESCRIPTION OF THE METHODS PRACTISED IN THAT INSTITUTION.*

BY GEORGE H. ROHÉ, M. D.,

Director,

AND WM. J. TODD, M. D.,

Resident Physician.

(Continued from page 197.)

The following statistics of one hundred cases confined in this institution between the dates mentioned in the beginning of this paper are added, as a contribution to the statistics of labor in American Maternity Hospitals. The tables give the figures in detail, divided into classes of twenty-five each. As a general summary, the following may be given: there were

Whites	60
Colored	40
American	88
German	5
English	2
Irish	4
Scotch	1

The average age was 23 years.

Oldest 40 years.

Youngest 14 years.

The most frequent time of beginning of labor was between 12, midnight, and 3 A. M.

	hrs. min.
Average duration of 1st stage,	11 4½
" " 2nd "	1 26½
" " 3rd "	0 9½
" entire labor	13 21½

Method of delivery of Placenta:

Credé	83 times
Spontaneous	12 "
Manual (intrauterine)	5 "

Result to mother:-

Perineum intact	58
---------------------------	----

*Read before the Medical and Chirurgical Faculty of Maryland, at its 91st annual session, April 25, 1890.

Perineum lacerated 1st, degree 40		of iliac crests, 10½ in., external conjugate, 7½ in.
" " 2nd, " 1		Divided as to race:
" not stated.		1st. 25, White 14
Discharged recovered . . . 99		Black 11
Died (uremic poisoning) . . . 1		2nd. 25, White 17
Ergot given in . . . 24 cases		Black 8
" not given in . . . 75 "		3rd. 25, White 15
not stated. . . 1 case		Black 10
Chloroform given in . . . 5 cases		4th. 25, White 14
Quinine " in . . . 2 "		Black 11
Forceps applied . . . 5 times		Total, White 60
Of the Children there were:		Black 40
Males 52		Nativity:
Females 48.		First 25 Patients:
Delivered living . . . 97		Maryland 16
" dead . . . 3		Virginia 3
(Two of these were premature deliveries at 4-4½ months and 5-6 months.)		Delaware 1
Presentation:		Indiana 2
Vertex 89		New York 1
Breech 2		Germany 1
not stated 9		England 1
Position:		25
Of 91 cases noted, there were		
L. O. I. A. 53		Second 25 Patients:
R. O. I. A. 31		Maryland 16
L. O. I. T. 1		Virginia 2
R. O. I. T. 1		W. Virginia 1
L. O. I. P. 3		New York 1
L. S. I. A. 2		New Jersey 1
The foetal heart pulsations were noted 68 times. Of these the quickest was 144 beats; the slowest was 108 beats.		Penna. . . . 1
(Predictions of sex based upon the frequency of heart beats were sometimes made, but not always successfully.)		Germany 1
The average weight of the children was 6.715 lbs. Heaviest 10 lbs. Lightest 1 lb.		Ireland 1
There was a general loss in weight between birth and the third day after. The greatest loss amounted to 1 lb.		Scotland 1
Smallest $\frac{1}{15}$ lb		25
Average loss $6\frac{1}{6}$ oz. Av.		
The average weight of the placenta was 1 lb $3\frac{1}{2}$ oz.		Nativity.
The placenta was delivered with foetal side out in 71 cases; with uterine side out in 26 cases; in fragments in 3 cases.		3rd 25 Patients:
The average measurements of the pelvis externally were between ant. sup. sp. processes, 9.77 in., between widest part		Maryland 14

Nebraska . .	1		Between 12 A. M. and 3 A. M. incl.	40
D. Columbia . .	1		" 3 "	6
Ireland . .	1		" 6 "	9
England . .	1		" 9 "	12
Germany . .	1		" 12 M. "	3
		25	" 3 P. M. "	11
			" 6 "	6
			" 9 "	11
			" 9 "	7
			Not stated	7
Total	Maryland	57		
	Virginia	12		
	W. Virginia	4		100
	Delaware	1		
	Indiana	2		
	New York	2		
	New Jersey	1		
	Penna.	4		
	Ohio	2		
	N. Carolina	2		
	D. Columbia	1		
	Germany	5		
	England	2		
	Ireland	4		
	Scotland	1		
		100		
	Age of patients:			
1st 25	Sum	591		
	Average	23 ¹⁶ ₂₅		
	Oldest	30		
	Youngest	17		
2nd 25	Sum	581		
	Average	23 ⁶ ₂₅		
	Oldest	36		
	Youngest	18		
3rd 25	Sum	556		
	Average	22 ⁶ ₂₅		
	Oldest	40		
	Youngest	14		
	Age.			
4th 25	Sum	576		
	Average	23 ¹ ₂₅		
	Oldest	32		
	Youngest	14		
	Total Sum,	2,304		
	Average	23 ¹ ₂₅		
	Oldest	40		
	Youngest	14		
	Hours of the beginning of labor pains.			
	The time the patient notifies the nurse is			
	not taken as the beginning of the first			
	stage, the patient is questioned closely as			
	re those in the same ward, and this in-			
	formation is used subjectively.			
	Duration of 1st and 2nd stages com-			
	bined; was not able to say when second			
	stage commenced.			
	In the 1st 25 cases, four cases so noted:			
			hrs. min.	
	Average time		5	35.

	hrs.	min.		Lacerated to second "	1
In the 2nd 25 cases, 2 so noted, average time	6	42.		Not stated	1
In the 3rd 25 cases, 2 so noted, average time	13	12½.			100
In the 4th 25 cases, 2 so noted, average time	6	34.			
				Disposal of patients.	
1st 25 cases, Credé method	24			Discharged fully recovered	99
By fingers in the uterus	1			Died of uremic poisoning	1
2nd 25 cases, Credé method	21				
By spontaneous	4				
3rd 25 cases, Credé method	16				
By fingers in the uterus	2				
Spontaneous	7				
4th 25 cases, Credé method	22				
By fingers in the uterus	2				
Spontaneous	1				
Total, By Credé method	82				
By fingers in the uterus	5				
Spontaneous	12				
	100				
Condition of perineum after delivery of child.					
1st 25 Intact	14				
Lacerated to first degree	11				
2nd 25 Intact	13				
Lacerated to first degree	12				
3rd 25 Intact, (Head enucleated twice)	13			1st 25. No ergot given in 18.	
Lacerated to first degree	10			Over 3 i ergot given in 6.	
Lacerated to second degree	1			Not stated 1.	
Not stated	1				
4th 25 Intact, (Head enucleated once)	18			2nd 25. No ergot given in 21.	
Lacerated to first degree	7			Over 3 iss " 4.	
Total, Intact, (Head enucleated twice)	58			Of above,	
Lacerated to first degree	40			Chloroform to partial anaesthesia in 2nd stage, 1.	
				Quin.sulph., grs. x, 2nd stage, 2.	
				Whiskey for shock, 3rd stage 1.	
				3rd 25. No ergot given 20.	
				Ergot given 5.	
				Average, mliv.	
				Of above, chloroform partial anaesthesia, 2 stage, 3.	

4th 25, No ergot given	16.	L. O. I. P.	3
Ergot given, aver.	31	L. S. I. A.	2
Of above, Chloroform	1.	Not stated	9
Whiskey	1.		100
Total: Ergot not given	75 cases.	Pulsation of fetal heart between pains.	
Ergot given	24 "	1st 25 cases. Time noted	18
Not stated	1 "	" not "	7
Chloroform	5 "	Average pulsation	128
Quinine sulph.	2 "	Quickest	140
Whiskey	2 "	Slowest	108
Statistics as to infant's sex:		2nd 25 cases. Times noted	20
1st 25 cases, Males	14.	" not "	5
Females	11.	Average pulsation	123.3
2nd 25 cases, Males	15.	Quickest	140
Females	10.	Slowest	112
3rd 25 cases, Males	13.	3rd 25 cases. Times noted	17
Females	12.	" not "	8
4th 25 cases, Males	10.	Average pulsation	124 $\frac{1}{2}$
Females	15.	Quickest	144
Total: Males	52.	Slowest	112
Females	48.	4th 25 cases. Times noted	13
Position of head;		" "	12
1st 25 cases.		Average pulsation	127 $\frac{9}{16}$
L. O. I. A.	13	Quickest	140
R. O. I. A.	7	Slowest	112
L. O. I. T.	1	Total. Times noted	68
R. O. I. T.	1	" not "	32
L. O. I. P.	1	Average	125 $\frac{5}{8}$
Not stated	2	Quickest	144
	25.	Slowest	108
2nd 25 cases.		Weight of child at birth:	
L. O. I. A.	13	1st 25 cases	168 $\frac{13}{16}$
R. O. I. A.	8	2nd 25 "	176 $\frac{1}{16}$
L. S. I. A.	2	3rd 25 "	174
Not stated	2	4th 25 "	152 $\frac{5}{8}$
	25.	Total	671.5
Average weight			670 $\frac{5}{8}$
Heaviest child			10
Lightest "			1
4th 25 cases.		Weight of child the third day.	
L. O. I. A.	16	Of the first twenty-five, twenty-four were weighed,	160 $\frac{1}{2}$ lb
R. O. I. A.	5	Of the second twenty-five, twenty-four were weighed,	160 $\frac{1}{2}$ "
Not stated	4	Of the third twenty-five cases,	164 $\frac{3}{8}$ "
	25.	Of the fourth twenty-five cases, twenty-two were weighed,	140 $\frac{1}{2}$ "
Total. L. O. I. A.	53	Total	625 $\frac{1}{2}$ "
R. O. I. A.	31		
L. O. I. T.	1		
R. O. I. T.	1		

Average weight at third day,	$6\frac{8}{15}\frac{9}{2}$ "
Heaviest at third day,	9 " "
Lightest, " "	$4\frac{1}{16}$ "
Greatest loss between weight at birth, and weight at third day	1 " "
Smallest loss between weight at birth, and weight at third day,	$\frac{1}{16}$ "
Average loss as above,	$6\frac{1}{2}$ "
Retained the weight at birth not gaining or losing,	1 case
Gained in weight over that at birth,	1 case, $\frac{1}{8}$ lb
Weight of infant at sixth day.	
Of the first twenty-five cases, twenty-two were weighed	$154\frac{1}{4}$ lb
Of the second twenty-five cases, twenty-three were weighed	$153\frac{5}{8}$ "
Third twenty-five cases	$171\frac{1}{8}$ "
Of the fourth twenty-five cases twenty-two were weighed,	$146\frac{8}{15}$ "
	— " "
Total	626 "
Average weight at sixth day,	$6\frac{18}{25}$ "
Heaviest weight at sixth day,	$9\frac{5}{8}$ "
Lightest " " "	4 "
Greatest gain in weight over weight at birth,	$\frac{3}{4}$ "
Greatest loss in weight compared with weight at birth,	$1\frac{1}{8}$ "
Average gain of those that did gain, compared with the weight at birth,	$3\frac{2}{3}\frac{1}{4}$ "
Average loss of those that did lose, compared with weight at birth,	$5\frac{3}{5}\frac{9}{16}$ "
Placenta Weight.	
1st 25 cases total weight	$30\frac{1}{8}$ "
Average	$3\frac{7}{5}\frac{1}{2}$ "
Heaviest	$1\frac{1}{2}$ "
Lightest	$\frac{9}{16}$ "
2nd 25 cases total weight	$29\frac{3}{4}$ "
Average	$3\frac{1}{2}\frac{1}{2}$ "
Heaviest	$1\frac{3}{4}$ "
Lightest	$\frac{7}{8}$ "
3rd 25 cases total weight	$30\frac{13}{16}$ "
Average	$3\frac{1}{2}\frac{1}{2}$ "
Heaviest	$1\frac{1}{2}$ "
Lightest	$\frac{7}{8}$ "
4th 25 cases total weight	$30\frac{1}{8}$ "
Average weight	$3\frac{2}{5}$ "

Heaviest	2 "
Lightest	$\frac{7}{16}$ "
Total weight	$120\frac{13}{16}$ "
Average " "	1lb $3\frac{3}{16}$ oz.
Heaviest "	2 lb
Lightest "	$\frac{7}{16}$ "

Placenta:

The side of the placenta delivered first:	
1st, 25 cases, Uterine side	10
Fetal side	15
2nd, 25 cases, Uterine side	5
Fetal side	20
3rd, 25 cases, Uterine side	6
Fetal side	18
In parts	1
4th, 25 cases Uterine side	5
Fetal side	18
In parts	2
Fetal side out	71
Uterine " "	26
In parts	3
	100

Infants born alive 97

Still births 3 100

Of the still births, the utero-gestation of two was about 4 to $4\frac{1}{2}$ months, of one at about 5 to 6 months. The mothers of the first two still-born children were admitted to hospital in labor. The mother of the last still-born child had had been in the hospital two days.

in case thirty, the mother was admitted to hospital in labor, delivered of a live infant, of utero-gestation of about $6\frac{1}{2}$ months, which lived 2 hrs and 7 min.

External Measurements of Pelvis between Ant. S. S. Processes:

1st 25 cases.	19 patients measured	179 $\frac{1}{2}$
2nd 25 cases.	25 patients measured	236 $\frac{5}{8}$
3rd 25 cases.	23 patients measured	215
4th 25 cases.	22 patients measured	213 $\frac{3}{4}$
		(89)844 $\frac{5}{8}$

 $9\frac{54}{65}$ Average 9 $\frac{5}{11}$ inc.

Between widest part iliac crests:

1st 25 cases.	19 patients measured	196
---------------	----------------------	-----

2nd 25 cases.	
25 patients measured	257 $\frac{1}{4}$
3rd 25 cases.	
23 patients measured	235 $\frac{1}{4}$
4th 25 cases.	
22 patients measured	230 $\frac{1}{2}$
	89) 920 $\frac{1}{4}$
	$10\frac{121}{356}$
Average	10 $\frac{1}{2}$ inches
Ext. Conj. diam.	
1st 25 cases: 19 patients measured	135 $\frac{1}{4}$.
2nd 25 cases: 25 patients measured	181
3rd 25 cases: 23 patients measured	176 $\frac{1}{2}$
4th 25 cases: 22 patients measured	166 $\frac{2}{3}$
Total: 659 $\frac{19}{4}$ ÷ 89 = 7 $\frac{83}{2136}$ Av. 7 $\frac{2}{7}$ in.	

FORCEPS DELIVERIES:

Case 1479: Labor began May 25 1 A. M.
Delivery " 25 4.46 A.M.

Position of head L. O. I. P.—this fact and the history of a former delivery with forceps of a dead infant, also that the head had been in the perineum two hours, decided to deliver with Simpson's forceps, child alive and discharged with mother.

Case 1499: Labor began Oct. 1st 1 A.M.
Delivery " " 7 P.M.

Head of infant would not engage at superior strait. Patient was placed under the influence of chloroform and Hodges' forceps applied by Prof. Rohé, forceps on the head 15m.

Respiration and circulation of the infant was feeble. Child was placed in a basin containing hot water, then a basin of cold water, alternatively; with desired success.

Case 1535: Labor began Oct. 12, 5 A.M.
Delivery " 13, 1.55 P.M.

Head would not engage at the superior strait. Hodge's forceps used by Prof. Rohé. Instrument on the head 23 min.

Case 1542, 1st pregnancy:
Labor began Oct. 1, 7.30 P.M.
Delivery " " 2, 9.32 P.M.

Head of infant rested on the perineum for three hours, the contractions of the uterus not being of sufficient force to expel the infant.

Quinea sulph. was given, with little effect. The contractions becoming less

frequent, patient was chloroformed and Simpson's forceps applied by Dr. W. S. Gardner. He had them on the head 8 minutes. Infant taken without rupture of the perineum.

Case 1549:

Labor began Oct. 11, 12.05 A. M.
Delivery " " 12, 6.35 P. M.
Head at inferior strait two hours.
Simpson's forceps applied by Prof. Rohé.
Infant delivered successfully.

LEPROSY, WITH REPORT OF
A CASE.

BY ROBERT HOFFMAN, M. D.,
OF BALTIMORE.

(Concluded from page 180.)

On the dorsal surface of the right foot corresponding to the base of the 5th toe, there has formed since yesterday a tense, filled pemphigus bleb, also on the inner surface of the left foot a similar bleb of an oval shape and somewhat larger. The contents show but very few bacilli and a small number of the above described red and green cells.

May 19th. Patient feels somewhat easier, can leave his bed to be carried into the garden. The first attempt to do so to-day, was followed by fever in the evening. After remaining up for a short time his feet and legs swell. Gums are swollen and doughy. The knotty infiltrations of the hard and soft palate are spreading out gradually, fading away with deep furrows between them. Laryngoscopical examination reveals no change. Wasting of the body very pronounced. The skin of the back and arms can be raised in great folds, that of the arms hanging loosely. Patient has lost in weight since his illness 16 pounds. Particularly is the wasting of his face noticeable. The cheeks are sunken. Diarrhoeic stools. Patient has no control over his bowels. The nails of his toes and fingers are as thin as paper,

The lymphatic glands have become normal in size and soft to the touch.

May 25th. Patient's weight is gradually increasing. The appetite is good, but he complains of not being able to taste the food he takes, and at times of nausea at the sight of it.

On testing the sense of taste by painting sugar, quinine and a solution of salt over the infiltrated parts of the soft palate, I find, that it is very nearly absent. At the base of the tongue he is better able to distinguish the various solutions. The sense of smell is very much diminished. Ammonia, turpentine, muriatic acid, acetic acid and ether are not at all distinguished or even noticed, but are distinguished by breathing through the mouth. Laryngoscopical examination reveals no change. Particularly striking is the excessive hoarseness of the voice in spite of the ready response and uninterrupted movements of the vocal cords. He sleeps soundly. Diarrhoea still continues, not bloody.

June 9th. Patient leaves hospital in an improved condition, is able to go up the steps. Voice hoarse and only audible after a decided effort, ordinarily aphonic. Epistaxis ceased, wound on the left arm scarred.

June 17th. The first days after he was dismissed from the hospital patient remained in fair condition, but three days ago he rapidly grew worse. He created such an unpleasant odor about the premises that his boarding mistress ordered his immediate removal. He again grew weaker so that he was hardly able to move. Two days ago his right nostril was cauterized with the galvano-cautery. This was only done after his most pressing and persistent wishes. Patient claimed to have gotten relief from this procedure; shortly, however, severe pains were felt in his nose, gradually affecting the frontal region of his head. Since yesterday patient complains of chills and to-day he had severe rigors. Patient can hardly walk. He was put to bed at once when he passed into a profound sleep or stupor; his respiration was of the Cheyne-

Stokes type—ranging about 15 respirations in 10 to 20 seconds. The conjunctiva around the cornea partly overlapping it has taken on a yellowish white color. The eyelids are infiltrated. On the lower lips and nose numerous small yellowish translucent bumps have appeared. The infiltrated portions of the pharynx are rapidly breaking down. Lungs are normal. Over the apex of the heart a systolic and diastolic murmur can be heard. Liver considerably enlarged, feels hard and irregular to the touch, splenic dullness increased. Sensibility has increased in the skin of the back, so that the slightest touch can be felt. He, however, cannot distinguish whether he has been touched with a pointed or dull edge. That of the arms and legs is not changed. There is no blood in urine nor albumen. Patient left for the city of Augsburg, where he died in 2 weeks. No post-mortem.

The following points in this case seem to be of interest:

1. We have the two principal forms of leprosy distinctly marked. The lepra tuberosa, and the lepra anaesthetica, which again manifest in more or less degree the subordinate form of lepra maculosa, all of these varieties in the same individual at the same time. This, then, proves the assertion made above that the various forms of leprosy combine, due, however, to only one cause, that it is not true as formerly advocated that the various forms of leprosy or pathological manifestations were due to various and distinct causes. The combination of the various and distinct forms must not be thought to develop at once, but we must assume that one form gradually develops out of the other, or that there is a transformation of one into the other, and in such a manner that the preceding form in spite of the development of the new one, still continues. Wernich, a German observer in Japan, maintains that he has never seen one isolated form of leprosy, but only a combination and transformation of one stage into another. Our patient shows the characteris-

ties of the two principal forms, one of which is marked by the presence of tuberous and nodular formations in the outer skin, the other particularly marked by a more or less developed anaesthesia, either on the whole body or in circumscribed patches. Particularly well and noticeably marked in this case is the already described leontiasis which gives a dark fierce lion-like expression to the face.

The anaesthesia has developed in him in some parts to an analgesia, so that a needle can be pushed to the bone in his lower extremities without ever having the slightest sensation.

Very interesting in this patient is the fact that during the latter part of his stay in the hospital, sensibility increased. In the literature on this subject, we find no mention of this fact. The improvement might be explained by the gradual resorption of the infiltrations in the skin, especially those around the nerves. It has been shown that the nerves of lepers are often surrounded by a larger infiltration, 3-4 mm. thick and with well pronounced cell formation, which causes the highly marked anaesthesia. We can, therefore, readily understand that a resorption of these cell masses surrounding the nerves would make a gradual return of sensibility possible.

As before remarked, Hansen was the first who demonstrated the bacillus of leprosy. After his discovery many others found them, among them Neisser who described them minutely. He found them always in all the new formation of leprosy as well in the new formation of the skin, in the nodules and also in more diffuse infiltration. They were nearly always found in the interior of the large cells which Virchow described as lepra cells, either completely permeating the protoplasm or in small masses arranged in closely packed rods. Neisser never demonstrated them in the blood vessels. In this particular case Dr. Müller, now professor at Breslau, and myself demonstrated the presence of these bacilli not only in the serum of the pemphigus blebs, but also in the blood. The method which

we have adopted in demonstrating these micro-organisms was described in the preceding pages devoted to the clinical history. The bacilli are little slim rods, in length $\frac{1}{2}$ - $\frac{3}{4}$ of human blood cells. As Neisser never succeeded in finding the bacilli in the blood of the lepers, he thought that they were transmitted throughout the body by the lymphatic system. This view seems to be correct when we consider the arrangements of the bacilli particularly in the adventitia of the circulatory system, which we know contains lymphatic spaces. Again the considerable swelling of the glands in which always masses of bacilli can be found. We might be justified in believing after the demonstration of bacilli in the blood in this case, that the circulatory system might also be a means of carrying them to the various portions of the body, however, further experiments are necessary to enlighten us on this point.

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Society Reports.

CLINICAL SOCIETY OF MARYLAND.

STATED MEETING, HELD MAR. 21ST, 1890.

The 231st meeting of the Clinical Society of Maryland was called to order

by Dr. I. E. Atkinson; the President and Vice-President being absent.

Dr. R. M. Hall exhibited a specimen of

FIBRINOUS CAST FROM THE UTERUS.

He related the history of the case and showed that there was nothing in it pointing to the presence of such a condition.

He then read the history and report of autopsy of a case of

PENETRATING WOUND OF THE HEART which was followed by septicemia.

Dr. W. S. Gardner said that he thought that by cleansing out the debris from the uterus of the second case, good would surely have been done. He thinks the case was one of sapraemia and not septicaemia or that conditions where the organisms are found in the blood.

Dr. J. H. Branham thought that the elevation of temperature in the second case was due to trouble in the uterus. The date concerning the time at which abortion took place is so uncertain that it is hard to get at the medico-legal points connected with the case. The specimen of fibrinous cast shown from the first case related by Dr. Hall looks more like a washed out blood clot than a fibrinous exudation.

Dr. I. E. Atkinson said that he had never seen such a cast as the one here presented to come from the uterus but he has observed the whole vagina occluded by a fibrinous cast.

Dr. R. B. Norment said in reference to the first case as the woman had been troubled with a discharge at a recent date, it looked as if the cast may have been a washed bloodclot. He had seen a case where similar mass was discharged, and on examination a small embryo was found inclosed in it. In regard to the second case, if it was not a condition of septicaemia, how do we explain the fatty degeneration which we found to have taken place in the different organs?

Dr. W. S. Gardner said that the high temperature was all that was required to

explain such a condition. Experiments have shown that where animals are subjected to high temperature influences the same fatty change goes on even though no organisms are found in the blood.

Dr. A. K. Bond said that as elevation of temperature took place in the second case, after an examination had been made, it is possible that infection resulted from poison being carried in at that time.

Dr. Herbert Harlan related

A CASE OF DISEASE OF THE MASTOID BONE

and exhibited a number of pieces of bone he had removed from it. Patient, boy, æt. 7 years, who came to the Presbyterian Eye, and Ear, Hospital with his face very much swollen. There was present behind the ear, a hole from which pus was streaming. The introduction of a probe showed the presence of bone. The patient was anaesthetized and the fragments of bone were taken out. The wound was washed out, and the swelling rapidly subsided. At the end of one week he was greatly improved. Facial paralysis followed the operation. The interesting point about the case is the quantity of bone that was removed. Suppuration had been going on for two years. From the examination of the fragments, it shows that about all of the petrous portions of the temporal bone was taken away. These troubles usually start in the middle ear and pass into the mastoid cells. It is interesting in this case to note that nature accomplished so much without doing damage. Treatment could have been carried on here in the beginning, by first treating the trouble in the middle ear, after that, the mastoid cells, and later on if necessary, the bone could have been removed.

Dr. Hiram Woods said that he had operated on several of these mastoid cases. It seems that in children recovery takes place better than in adults. In infancy these troubles can occur and mean very little. One question to be

considered is, whether these mastoid troubles are secondary to affections of the middle ear, or do they occur simultaneously with them? Recent pathologists seem to take the latter view. After it once has occurred, the bones break down and this condition presented by Dr. Harlan takes place.

He saw this same patient and he (patient) did not suffer much pain. In adults the condition is usually preceded by middle ear troubles. In regard to the operative measures, he thinks that much chiseling is done unnecessarily. Probably he errs on the conservative side, but he has not seen a single case that he has failed to relieve, and that too, without chiseling. The use of leeches will bring about marked improvement in adults.

Dr. R. L. Randolph said apropos of this, he saw a case about three months ago where a diagnosis of mastoid abscess was made. There was a large opening over the mastoid bone. This patient was operated on, and through a small opening in the bone a cavity was found in which was present about one teaspoonful of caseous pus.

Dr. John W. Chambers asked if it was the habit to trephine the mastoid bone in these conditions?

Dr. Herbert Harlan said this operation is now rarely done. Sometimes it happens that pieces of bone escape through the external auditory meatus and relief comes in this way.

W. J. JONES, M., D. Sec'y,
1228 Greenmount Ave.

HEREDITARY CHOREA IN ADULTS.

Dr. Bernatski reports in a Polish medical journal a case occurring in the Warsaw University Clinic of the so-called "Huntington's chorea," or chronic hereditary St. Vitus's dance in adults. According to the accounts of it given in medical literature, it is an extremely rare affection, appearing in adults and being complicated with mental disturbance.

It is hereditary, whole families being affected by it. Irregular incoördinate movements appear first in the facial muscles, and afterwards spread to those of the upper extremities and of the trunk. These movements become arrested or diminish during voluntary movements, this constituting, according to Landois, a pathognomonic symptom distinguishing the affection from St. Vitus' dance as described by Sydenham. The majority of authors who mention the disease describe it as incurable. *Dr. Bernatski's* patient was a man of forty-eight years of age, a shoemaker by trade, who, when admitted, had been suffering from choreic movements for five years. His mother and his maternal grandfather had been similarly affected. The movements occurred in the head, face, the upper extremities, and in the trunk. At first bromide of potassium was prescribed to the amount of sixty-two grains per diem. This, however, was quite useless, the movements continuing as before. Liquor, arsenicalis—that is, of course the Russian one, which is stronger than that in the British Pharmacopœia, in the ratio of 6 to 5—was then ordered: six drops per diem were given at first, being gradually increased until ten drops daily were taken. After four days of this treatment there was some perceptible improvement, and by the eleventh or twelfth day the involuntary movements had very nearly ceased, the fingers only showing signs of them. It would, therefore, appear that arsenic is indicated in this disease, and affords some hope of cure. The patient referred to left the hospital and was not seen again.—*Lancet.*

In the University of Berlin the academic year will henceforth be divided into a winter and summer *Halbjahr* (half year), the term "semester" hitherto in general use being proscribed, probably in deference to the ultra-Teutonic spirit which is at present insisting on the expurgation of the German language from all taint of foreign influence.

MARYLAND MEDICAL JOURNAL

Weekly Journal of Medicine and Surgery.

WILLIAM B. CANFIELD, A.M., M.D., Editor

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BALTIMORE, JULY 12, 1890.

Editorial.**SALICYLIC ACID IN
DERMATOLOGY.**

The germicide properties of this well known agent have been carefully determined. Sternberg found that a pus micrococcus in active growth was destroyed by a 2 per cent. solution of the acid, and that the bacterium *termo* was killed by a like solution. As unusual skill and care is needed for the preparation of the pure acid, many samples to be had from druggists are unsatisfactory in their action upon the skin, chiefly on account of the presence of carbolic acid.

The action of pure salicylic acid upon the skin is quite peculiar. When a plaster or ointment con-

taining from 38 to 50 per cent. of salicylic acid has been applied, the epidermis beneath it becomes gradually white and soft, so that it may be scraped off with the back of a knife. A reddened oozing surface is exposed, upon which, by the aid of a lens, the papillæ, rich in vessels and nerves, may be seen, projecting like so many carrots planted irregularly, with their roots up. Very little or no dermatitis is excited in the parts surrounding the application, except in cases of peculiar idiosyncrasy.

In the *Johns Hopkins Hospital Bulletin*, April, 1890, Dr. Morison calls attention to these facts concerning salicylic acid, and mentions certain cases in which he has found it of value. He first saw it used at a clinic at Prague in 1882, and found it in respect to cleanliness to greatly surpass and in efficiency to equal the ill-smelling tar preparations of the Vienna clinics. He uses it now quite extensively in his practice.

It is a good remedy for *freckles* and other *pigmentations*, as it readily removes these blemishes, and, in his experience, never of itself causes deposit of pigment. Through its germicide properties it quickly destroys the growths of *tinea versicolor* and *ringworm*. A case of chronic and very obstinate ringworm of the face and arm is cited, in which each spot was washed for five minutes with *sapo viridis* and warm water, and then covered with a solution of bichloride 15 grains and salicylic acid 60 grains in an ounce of collodion. There was intense pain and slight blistering, but no further application was required except lanolin containing 5 per cent. of salicylic acid. The cure was very remarkable.

Chronic *eczema* yields readily to the stronger salicylic preparations. In one

case, a healthy man of 45 years consulted him concerning a chronic squamous eczema of the wrist and palm. It worried the patient very much, especially when he became warm in bed, and had for two years resisted all treatment. A 38 per cent. salicylic acid plaster was applied and fastened tightly to the affected parts by means of a bandage. As the skin was not much affected after 24 hours, a fresh plaster was put on. This application, unlike the former one, caused intense pain, and upon its removal next day the epidermis was found to be soft and white. Without disturbance of the dead epidermis, a 50 per cent. ointment of salicylic acid in lanolin was rubbed in frequently and kept on by gloves. In from 7 to 10 days a complete cure was produced. The patient was discharged, with orders to rub a little of the 5 per cent. ointment on the parts which had been diseased every time he washed with soap and water.

The salicylic acid treatment is of great value in *psoriasis* of long standing. A case is related in which a man had suffered for 20 years from psoriasis numulata et orbicularis, having large spots on the forehead and on both sides of the nose. Sapo viridis and hot water were used to remove the scales, and an ointment containing 60 grains of salicylic acid to the ounce of lanolin was rubbed into the affected skin. In a week considerable improvement was noticed, and at the end of a month only a slight discoloration could be observed on the face, which had once been greatly disfigured, and the lesion on the other parts of the body were also disappearing.

Salicylic acid may be applied in several different ways. It is only slightly soluble in water, but dissolves more readily in this liquid when sodium baborate is added.

When it is desirable to apply it in powder to the skin, Dr. Morison prefers to make a saturated solution in alcohol, which dissolves it readily, and to allow the alcohol to evaporate leaving the acid behind in the form of a very finely divided powder. Unna rubs the powdered salicylic acid up with gelatine and glycerine, no solution being formed, but a useful mixture. Ointments of various strengths may be similarly prepared with lanolin. Unna has prepared plasters, containing from 5 to 50 per cent. of salicylic acid, which have rubber backs and stick well to the skin.

OUR CITY STREETS.

The recent complaint made in Boston and New York of the city streets were well grounded. Baltimore has a natural advantage in the hills which, during rains, allow much of the dirt and filth of the city to be carried off by the surface drainage. The fact, therefore, that this city is so clean, is in nowise to be attributed to the activity of the Street Cleaning Department.

This Department probably sweeps and cleans the streets as far as its force will allow, but its method of stirring up dry dust is to be strongly condemned. The indolent sweepers are preceded by a man with a small water-pot who dashes a few drops of water here and there over the streets. As soon as the sweeping begins, the effect of the water is not noticed and clouds of dust are raised.

This has it advantages to the Department, for much of the dust which should be carried off by the carts, is deposited in the open windows of the neighboring houses, or is carried off by the obliging

yet unwilling passer-by in his clothes, hair, and breathing apparatus.

When we consider the number of consumptive people that expectorate in the street, and the tenacity to life of the spores of the tubercle bacillus, it can be very easily seen that the present system of dry sweeping is a very effective way of spreading at least one disease.

And in this connection it is astonishing how nature endeavors to protect us from the "deadly dust" and its germ contamination. For this inhaled dust does not reach the lungs easily, but with great difficulty, for in its passage through the nostrils, the moist secretion causes some of the dust to stop while its acidity may destroy invading micro organisms. Those that get through the curved nasal passages, may irritate the sensitive epiglottis and be coughed up. Those that pass the glottic and epiglottic sentinels, may have the ciliated epithelium to contend with.

And yet, in spite of all these barriers, dust and micro-organisms find their way into the lung substance, and even the aggressive phagocytes of Metschnikoff cannot prevent the entrance of the tubercle bacilli which often enter in this way and find a good culture medium in a lung apex.

If the Health Department had control of the Street Cleaning Department, much of this might be obviated.

Reviews, Books and Pamphlets.

Rheumatism and Gout. By F. LE ROY SATTERLEE, M. D., Ph. D. New York, etc., etc. Detroit: Geo. S. Davis, 1890. Pp. 83. Price, cloth 50 cents, paper 25 cents

The author having gone through the suffering accompanying the diseases treated of, is able to discuss the subject very sympathetically. The value of the book lies undoubtedly in the author's views on treatment, this part of the work being most thorough and satisfactory. He gives the salicylates a low place in therapeutics, but gives his reasons for it. The book is short, practical and valuable even for those who may not agree with its teachings.

Transactions of the Eleventh Annual Meeting of the American Laryngological Association held in the city of Washington, D. C., May 30 and 31 and June 1, 1891. New York: D. Appleton & Co., 1890. Pp. 15.

Besides the president's address, this volume contains twenty-one papers, most of them valuable contributions to laryngology, and three descriptions of new instruments. This volume records the work of a small but earnest body of specialists, and their transactions take no second place to those of any country.

Communication from Jack the Ripper. Reprint from the *Medical Mirror.* St. Louis, May, 1890.

Apparent Cancerous Transformation of Syphiloma of the Tongue. Excision of the Tongue by Galvanic-Cautery. By G. FRANK LYDSTON, M. D., Chicago, Ill. Reprint.

Intestinal Anastomotic Operations with Segmented Ruber Rings, with some practical suggestions as to their use in other surgical operations. By A. V. L. BROKAW, M. D., St. Louis, Mo. Reprint.

Chloralamide as a Hypnotic. By W. HALE WHITE, M. D., F. R. C. P., London. Reprint.

Miscellany.

THE MEDICAL PROFESSION AGAIN DISREGARDED.

The *Maryland Medical Journal* says: "Governor Jackson has permitted the constitutional time allowed for signing bills passed by the General Assembly to go by without giving his signature to the Medical Bill. The bill, therefore, fails to become a law. The profession and the people of Maryland are left for another period of two years without protection from the annual invasion of medical quacks and incompetent practitioners squeezed out of other States into this State. His excellency has shown a spirit of narrow-mindedness and of prejudice utterly unworthy of a cultivated and enlightened executive. He has treated the medical profession of Maryland with the most marked disrespect and disregard." This is only another illustration of the trifling weight attached by politicians to medical opinions and wishes.

If this were because these opinions are weak and these wishes impracticable or hurtful, such treatment might be endured as being of educational value. But this is not the case.

As politics are conducted in this country, the politicians and the organized bodies of voters alone have any influence. If the profession of Maryland would regain their self-respect and secure their just requests, let them organize and vote together. A body of men representing two thousand votes would amount to something in the eyes of the authorities, but a body of men simply representing an important idea are of no use in politics.—*Medical Record*.

GERMAN MEDICAL DIPLOMAS.

A French exchange says: in the numerous small free faculties of Germany, the medical students pass their examinations in the following manner:

"Do you smoke?" asks their examiner.

"Yes, sir," answers the student.
"Will you have a cigar?" (*Hands the professor a pfennig cabbage leaf cigar*).

"Tell me," says the professor (*slowly lighting his weed*), "what are a physician's principal duties?"

"To collect his fees, increase his practice and exhibit his diploma from the time-honored 'University of Guzzleburg,'" replies the student.

"Where shall you practice?" demands the professor, "and what are your duties towards me?"

"I shall go to America among the ignorant natives and make a golden harvest. And my duty towards you, Herr Professor, is to invite you to dinner for the rest of the semester," answers the student.

The professor smiles and says: "You are right. Let us go to a restaurant opposite and I will sign your diploma. The diplomas of the time-honored 'University of Guzzleburg,' are admired and respected in America. I have a cousin who is a doctor in Chicago. Let me tell you how the Indians chased him on Prairie Avenue. He was wounded twice by their arrows and captured, but was released by his pursuers when they found on his person the time-honored diploma of the 'University of Guzzleburg.'" Ah! here's the restaurant, and I will make out your diploma from the time-honored 'University of Guzzleburg.'—*Cincinnati Lancet-Clinic*.

CATARRHO-ENTERITIS.

Let us assume a case of catarrho-follicular enteritis, with hot skin, vomiting, frequent stools of a malodorous, mucous character, containing some blood, the tenesmus marked although not intense, child nursing or being fed artificially.

1st. Withdraw all milk foods (very important)!

2d. Oat meal gruel or rice water.

3d. Cold drinks. Ice water or lemonade (abundant).

4th. Cool baths (often).

5th. Thin slip—the only clothing.

6th. Car ride into the suburbs, and sleep under shade trees if possible

7th. One-twentieth of a grain of calomel every half hour until ingesta have been removed and odor corrected.

8th. Half to one-drop doses of Fowler's solution every three hours, until mucus and blood disappears.

9th. Should vomiting occur frequently, and evidences of food fermentation marked, the following:

R. Acidi carbolicici	gr. iv
Bismuth subnit.	gr. 160
Tinct. cinamomi	3 iiij
Mucilag. G. acaciæ,	
Syr. G. acaciæ	3 ij

M. Sig.: Teaspoonful every four hours.

A number of such cases as described above have recently been treated, with almost invariable good results. After third day, milk or some of the milk foods may be given.—*St. Louis Clinique.*

HÆMATEMESIS IN A NEW BORN INFANT.

Mr. H. C. Hodges of Watton has published the notes of a case, under the care of his father, of hæmatemesis in a new-born child. The child, after a perfectly natural and easy labour, was born at 5 A. M. At 11 A. M. a very urgent message came that the child had hæmorrhage. It was found to be blanched and the pulse very feeble, and the clothes were saturated with bright blood which had been vomited. Absolute quiet was enjoined, and ten minims of hazeline every two hours were ordered. There was no more hæmorrhage, but about a tablespoonful of blood-stained mucus was vomited at 5.30 P. M. Hiccough had been constant since the morning. There was also one rather copious evacuation of blood, besides meconium. The next day the hiccough was less. There was a slight serous discharge from the left ear, and subconjunctival hæmorrhage of the left eye. On the second day after birth there was internal strabismus of the left eye. After the third day the symptoms rapidly disappeared and the child got quite well. Mr. Hodges was disposed to think that there had been some injury to the vessels at the base of the skull,—*Lancet.*

TO REMOVE THIRST.

Paint the tongues of your fever patients with glycerine; it will remove the sensation of thirst and discomfort felt when the organ is dry and foul.—*Weekly Medical Review.*

GONORRHOEA IN THE FEMALE.

The following formula is given (*Jour. de Med. de Paris*) for the above:

R.—Creolini	3 jss
Ext. Hydrast. Can.	3 iijs
Aq.	3 vij.—M.
Sig.—Add 3 ij. to a pint of water and use as an injection.— <i>Gaillard's Medical Monthly.</i>	

THE SPINAL CORD IN INFLUENZA.

At a meeting of the Royal Academy of Medicine of Turin on May 23rd, Professor P. Foà described the lesions which he had found in the spinal cord of a woman who died of influenza. The patient, who was "of middle age," had suffered from the usual symptoms, and the attack was followed by extremely acute bronchial catarrh, and later on by bronchopneumonia on one side, with hepatisation of the other lung. Sections of the spinal cord showed intense hyperæmia, its substance being dotted with minute red points. On microscopic examination, numerous hæmorrhagic foci were seen in all the divisions of the cord, notably in the upper two-thirds of the dorsal, and the upper portion of the cervical, region. There was recent infiltration of red corpuscles among the nervous elements, which were slightly separated and compressed, but not visibly altered in structure. Some of the vessels were obliterated, and it was in the neighbourhood of these that the hæmorrhages had taken place. Degenerative changes were also present in places, the axis cylinders being hypertrophied to five or six times their ordinary size, and the fibres degenerated. These degenerative foci were, as a rule, independent of the hæmorrhagic patches, but in the highest part of the cord the two lesions were sometimes found together. The hæmorrhagic foci were chiefly situated in the posterior columns, almost always at their periphery; the de-

generative foci occurred mostly in the lateral columns. Neither the grey matter nor the posterior roots showed the least alteration. Dr. Foà thinks that the lesions were due to occlusions of vessels, giving rise in some places to haemorrhage, and in others to alterations in the nutrition of the nerve fibres. He thinks it probable that the occlusion was caused by an accumulation of micro-organisms, but admits that he was unable to verify this conjecture. Examination of the brain was not permitted.

A NEW EXPECTORANT.

According to Dr. Schengut in the *Centralblatt für Therapie*, a new expectorant, the tincture of naregamiæ, has been tried in the clinic of Professor Drasche, of Vienna, in twenty-four cases. The drug was used in doses of from 1 to 3 Gm. daily, according to the following formula:

R	Tinct. Naregamiæ	1.0.30 Gm.
	Laurel Water	10-20 Gm.
D.	S.	10 drops at every hour.

The tincture naregamiæ is derived from a plant which is found in Goa, viz., *Naregamia alata* W. et A. The drug has proved useful as an expectorant, particularly in those cases in which there was much coughing with little secretion, or when expectoration was made difficult by thick, tenacious mucus. In cardiac cases, in two of which the heart was fatty, complicated with catarrh of the air passages, the tincture of naregamiæ proved very efficacious. This was also true of pulmonary emphysema, and only in the case of a woman suffering from marasmus, and who had been subject to dyspepsia, vomiting occurred on each occasion even after small doses. In cases of tuberculosis, expectoration was occasionally facilitated. In pneumonia, the drug was used in the stage of resolution, with copious crepitant râles, it was well borne, and favored expectoration. The drug had no effect on the circulation, the digestion, or the urinary secretion, and no toxic

symptoms were observed.—*Br. and Col. Druggist.—American Druggist.*

THE PRACTICE OF MEDICINE IN THE SOUTH.

Having thus disposed of the most perplexing problem of modern times, we can now profitably turn to the practice of medicine in the South. This appears to me very like the same occupation at home. If there are no far-famed leaders of the profession in Birmingham, they nevertheless have men who are called in consultation, and those who never do more than the calling. So, too, do they have big doctors and little doctors; those who are ever haunted by the dreadful secret of their own pre-eminence, as well as that subfamily of "Docs" who are not yet as macrocephalic as they will be a little later on, especially in the estimation of themselves; those who belong to the common, every-day, plenty-good-enough-for-me variety of practitioner, who sometimes hits a nail on the head, and more sometimes doesn't. They have doctors with horses and conveyances, and those without any awe-inspiring appurtenances. They have freshly hatched specialists, with bits of vitelline membrane and shell still fondly clinging to their puny persons, tell-taling the hoary ripeness of their experience. Besides these modern abortions they have the truly venerable humbugs, the fashionable quacks, the "orfully busy" general practitioners, interterant pile-doctors, and those vagrants who modestly advertise as "lately of the Polyclinic." They have the statuesque frowners and the lubricated smilers, the man who is *suaviter in modo* dealing with all womankind, and proportionately *fortiter in regard* to the size of his bills. They have the doctor who never speaks at the medical society, and was never known to publish anything at all, and his friend across the way who always speaks, and always say what has been already better said, and who was never known to leave anything unpublished, especially the cases he thinks he has seen, and those matters which he believes he knows.

"Mein Liebchen, was willst du noch mehr?"

The only *avis medicalis* I have not yet run across down here is the top lofty pontificate-professor. But though professors come low nowadays, we must have them. It is a matter of time merely, when they will erupt in this torrid zone, and then the mushroom will kindly step to the rear, and a little lively, too, please. Won't he, though?

In other words, they have just about what we have, only a trifle more so, because their medical laws are so strict; and perhaps, also, owing to the absence of a partisan board of health, there being only one party in the South.—E. C. WENDT in *Medical Record*.

Medical Items.

Small-pox is reported in Canada.

The infant mortality has been very high in Baltimore since the first of July.

F. A. Davis, of Philadelphia, will publish the Annual of Universal Medical Sciences for 1890, within a short time.

The American Society of Microscopists will hold its next meeting in Detroit, on the 12th, 13th, 14th, and 15th of August.

Dr. Willis G. Westmoreland, editor and founder of the *Atlantic Medical and Surgical Journal*, died on June 27.

The Eighteenth Annual Meeting of the American Public Health Association will be held at Charleston, S. C., December 16, 17, 18, 19, 1890.

The Lancet announces that the chair of mental pathology at the University of Berlin, made vacant by the death of Professor Westphal, has been accepted by Dr. Grashey, of Munich.

Dr. Brieger, whose name is favorably known for his original work in bacteriology and general pathology, has been appointed Extraordinary Professor in the University of Berlin.

The Editorial Department of the July number of *The Dietic Gazette* will be under the charge of Victor C. Vaughan, M. D., Professor of Physiology in the University of Michigan.

The Committee of the International Medical Congress to be held at Berlin, has decided to give their guests a grand farewell banquet, at an estimated cost of 15,000 marks (\$3,750).

A Ladies' Committee has been formed in connection with the International Congress to be held at Berlin to provide for the comfort and amusement of the wives of foreign practitioners during their stay in the German capital.

The well-known surgeon, Professor von Dittel has just celebrated his fiftieth anniversary of his taking his doctor's degree, receiving his numerous ovations not only from students, but from persons of various classes.

Dr. Paul Silex, who has for about six years past been Professor Schweigger's assistant in the Berlin University Clinic for Diseases of the Eye, has established himself as a private lecturer on Ophthalmology in Berlin.

The Triennial Astley Cooper Prize of £300 (\$1,500), for the best essay on "The Origin, Anatomy, Results, and Treatment of Tubercular Diseases of Bones and Joints" has been awarded to Mr. William Watson Cheyne, M. B., C. M. Edin., F. R. C. S.

Dr. W. Schule, Professor of Ophthalmology at Buda-Pesth, has been elected Rector Magnificus of that University for the coming year. The College of Professors at Vienna has chosen Professor

Zuckerkandl to be Dean of the Medical Faculty next year.

Professor Teichman, of Cracow, has announced his intention of sending his well-known collection of injected anatomical preparations to the exhibition to be held in connection with the forthcoming International Medical Congress at Berlin.

At a meeting of the Berlin Municipal Council on June 12 it was decided that a convalescent home for lying-in women should be established at the expense of the city. A sum of 140,000 marks (\$35,000) (£7,000) was voted for the purpose.

The American Association of Obstetricians and Gynaecologists will hold its next annual meeting in Philadelphia, Tuesday, Wednesday, and Thursday, September 16, 17, and 18, 1890, under the presidency of Dr. E. E. Montgomery, of Philadelphia, and in the hall of the College of Physicians.

The Mississippi Valley Medical Association will hold its annual meeting in Louisville, Ky., October 8-11, 1890, under the presidency of Dr. Joseph M. Mathews of that city. This popular organization may look forward to one of its most prosperous meetings under such favorable auspices.

A correspondent informs us that many of the professors and *Docentes* of the University of Berlin intend to hold special courses of from three to four weeks' duration immediately on the close the Tenth International Congress. He adds that strangers will find the various announcements on the bulletin-boards of the Charité Hospital and the University Clinics.

The *London Lancet* of June 28th, contains a very careful review of Drs. Liebig's and Rohé's book on Practical Electricity. The reviewer particularly praises the section devoted to the application of elec-

tricity in the treatment of disease. It is very gratifying to have such good work appreciated in England.

According to the *Boston Medical and Surgical Journal*, Dr. J. L. Williams, of Boston, proposes the adoption of the term "oristry" to signify the rapidly widening specialty of the dental and oral surgeon. The word is compounded of the initial part of *oral* and the terminal part of *dentistry*. Such terms are about as phonologically beautiful and correct as the word "urinalysis."

Dr. José de la Luz Hernandez, one of the oldest and most esteemed members of the medical profession in Havana, died on May 3rd, 1890. He took his degree in medicine in 1826, and up to a few ago took a most active part in public professional life. He was one of the pioneers of hygiene in Cuba, having given public lectures on the subject so far back as 1840, and having been instrumental in introducing many sanitary improvements in the city of Havana.

At a recent meeting the *Hufeland Society* of Berlin resolved to offer a prize of 700 marks (\$175) for an essay on the Influenza Epidemic of 1890, and another of the same amount for one on the Penal Responsibility of Physicians and Surgeons as regards the Use of Chloroform and other Inhaled Anæsthetics. The essay on the influenza epidemic must contain a history of previous epidemics of the same kind and of the one in question, and an analysis of the etiology, pathology, and therapeutics of the latter and of its sequelæ. The essay must be in the hands of Professor Liebreich (Berlin, N. W., Dorotheen-strasse, 34A) by April 1st, 1891, and must be in German, English, or French. The unsuccessful essays will be returned to the senders, if desired, by Oct 1st, 1891. The result will be published on July 14th, 1891.

MARYLAND MEDICAL JOURNAL.

VOL. XXIII. No. 12.

BALTIMORE, JULY 19, 1890.

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Original Articles.

VI.—DISEASES OF THE PUERPERAL PERIOD. PHLEGMASIA ALBA DOLENS.*

BY WILLIAM S. GARDNER M. D.

Lecturer on Obstetrics, College of Physicians and Surgeons.

The opinions as to the etiology of phelegmasia alba dolens are as plentiful as the writers upon the subject. The proven points are few, and these are so obscured by useless talk and useless names, that it is difficult to get a clear idea of them.

In 1712 Mauriceau described the disease and thought it due to a metastasis of the lochia—a theory which is still held to under a different name by some of the English authorities. Puzas, Liveret

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- The Colour of Negro Infants.—Hints to the Unfortunate.—An Antiseptic for Midwives.—Raising the Epiglottis.—Experiments on the Motor Areas in the Brain of the Orang-Outang.—Phenacetin in Typhoid Fever.—The Uncertainty of Malpractice Suits—Berlin Medical Congress.—Treatment of Acute Tonsillitis.—What is the Medico-Legal Status of the Abdominal Surgeon?—Case of Haemophilia—Chlorodyne Poisoning through the Mother's Milk. 251

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and others thought the disease was due to a metastasis of the milk towards the legs. These theories have both been exploded by the facts that phlegmasia dolens occurs in men as well as in women, in the arms as well as in the legs, and may be subsequent to many infectious diseases.

The real cause so far as I am able to ascertain has not been demonstrated, but we are familiar with certain facts from which inferences as to the probable cause can be drawn. Dr. B. B. Browne of this city told me that a professional friend of his attended three cases of labor in succession, within a very short period, and each of the women was attacked by phlegmasia dolens. Dr. Browne saw two of these cases: all of them recovered. Tyler Smith relates that a friend of his saw and treated a case of phlegmonous sore throat, and within twenty-four hours he attended three women in confinement, all of whom had phlegmasia dolens. Considering the rarity of the disease, its oc-

*Lecture at the College.

currence in such series as these points to the probability that the disease was communicated by the physicians. If the communicability of the disease is established then we must conclude that it is due to micro-organisms, even if their presence is not demonstrated; for we can conceive of nothing but a living organism that can be carried to a place and there multiply.

Another fact which goes to indicate that phlegmasia dolens is an infectious disease, is, that in the reports of cases where the records have been kept from the time of confinement, we find almost invariably noted that while the phlegmasia does not appear until ten days or two weeks after confinement, there has been only a few days post-partum, a rise of temperature and more or less tenderness in one or both iliac regions—symptoms which are known to be due to septic infection. A large per cent. of the cases of phlegmasia are associated with pyæmic abscesses in other parts of the body. The disease occurring in other than puerperal cases is always subsequent to a disease accompanied by some abraded epithelial surface. Mr. Van Buren of the Kensington Infirmary, relates a case in the *Lancet*, and gives the notes on the autopsy. He considers the disease an infectious one, and in this case thought the placental site was the route of infection. Tyler Smith calls attention to the relation between septicæmia and phlegmasia dolens, and says: "I believe that contagion and infection play a very important part in the production of the disease. I look on a woman attacked with phlegmasia dolens as having made a fortunate escape from the greater dangers of diffused phlebetis or puerperal fever."

Symptoms:—Nearly all attacks of phlegmasia dolens are preceded in the first days of the puerperal period by some other manifestation of septic infection, such as pelvic or general peritonitis. The disease itself is rarely established before or after twenty days post-partum. In the beginning there may or may not be a chill. In uncomplicated cases, there

is some rise of temperature, though it rarely goes high, and subsides to the normal long before the swelling disappears. In cases complicated by pyæmic abscesses, the temperature fluctuates as in pyæmia.

Pain in the affected limb is one of the first symptoms. This pain is increased by pressure or by motion. Swelling of the part comes on rapidly and is often as great as to double the size of the limb. It is white, tense and does not pit upon pressure, as is the case in œdema. The period of extreme distension lasts from two days to a week, and then gradually subsides—it being a month or often much longer before the limb returns to its normal size.

In some cases after the disease has progressed a few days, a hard, tender cord can be felt in the region of the crural; in other cases this condition precedes the swelling; in still others it is not present at all.

There is almost complete loss of muscular power in the affected limb.

Pathology:—The theories advanced and the contentions covering the pathology of phlegmasia dolens are equalled only by the discussion as to its cause. Since most of the uncomplicated cases of phlegmasia dolens recover, opportunities for post-mortem examinations of patients dying of this disease are rare, and consequently the true pathological condition cannot be said to have been demonstrated.

In most cases clots are passed in the crural or iliac veins or even in the vena cava, and a greater or lessser amount of inflammation in the surrounding connective tissue. Quite frequently, metastatic abscesses in other parts of the body are found. Busch, Erichsen, and others report autopsies showing inflammation of the cellular tissue of the thigh without implications of the veins or other marked lesions.

There has been much speculation concerning the condition which brings about the great swelling of the limb. It has been mentioned, that some of the earlier writers thought the swelling was due to

the determination to the leg of the milk or the lochial discharges. Among the more recent theories as to which is the first or essential lesion are these: crural phlebitis; inflammation of the cellular tissue; inflammation of the nerves; lymphangitis with cellulitis; inflammation of all the structures of the thigh.

The majority of physicians think that crural phlebitis and the resulting clot are the essential lesions, and that the obstruction to the circulation thereby causes the swelling of the limb. Quite a considerable number of eminent men think that the original lesion is a cellulitis, and that the phlebitis is only a coincident and not the essential lesion.

Fordyce Baker in writing upon this subject very aptly says; "Two elements are absolutely essential to constitute the true theory of any disease;—(1) that the assigned cause or condition should always be present when the disease exists; (2) that the disease should always exist when the assigned cause is present in its full development." The truth of these statements are so potent that further argument is unnecessary. Let us apply this standard to the two theories under discussion.

In favor of the theory that crural phlebitis is the essential lesion in phlegmasia dolens is the fact that the hard, swollen veins can often be felt during the progress of the disease; and the fact that inflamed veins filled with clots are often found on post-mortem examination. In opposition to this theory are the especially well known facts; that crural phlebitis has been proven repeatedly to be present by post-mortem examination when there was no phlegmasia dolens; and phlegmasia dolens has been present without the presence of any clot whatever in the veins. Admitting these statements to be true, and they undoubtedly are true, we can not fairly conclude that crural phlebitis or the clot, upon which the most stress is laid, is anything more than a coincident lesion. But in addition to this we have the statement of Barker that a number of times in the wards of Bellevue he has called at-

tention to the fact that the hard, cord-like condition of the cord came on several days after the phlegmasia was fully established. It has also been shown experimentally that complete obstruction of the crural veins caused only œdema of the leg without any resemblance to the condition found in phlegmasia dolens.

In favor of the theory that the inflammation in the cellular tissue is the essential lesion is the fact which Busch and others have called attention to, that phlegmasia dolens occurs independent of phlebitis, and with cellulitis as the *only* lesion shown on post-mortem examination. The cellulitis will account for the symptoms presented. The enormous swelling and tension of the limb though often spoken of as œdema is not œdema: it is hard, resistant and does not pit upon pressure,—a condition present only where the swelling is due to an inflammatory process. Again the clot in the veins is accounted for by the inflammation of tissues immediately surrounding the vessels. The process is the same that is constantly seen in ulceration,—the rarity of hemorrhage from that process being due to occlusion of the vessels from what may be termed a periphlebitis.

Taking these statements into consideration I think it is reasonable to conclude with Lusk and Wineke that the inflammation of the cellular tissue is the primary lesion.

Treatment:—What I have already said concerning the constitutional treatment of other cases of septic infection applies also to phlegmasia dolens. Prophylaxis is the most important part of the treatment. In uncomplicated phlegmasia dolens the temperature rarely calls for treatment; supporting the strength of the patient and controlling the pain are about all that can be done.

The local treatment requires some special attention. To assist the obstructed return flow of blood the limb should be elevated on pillows or by raising the foot of the mattress. In the first stage of acute tension the limb should be wrapped in cotton and oiled silk. A great variety of

lotions have been recommended for use at this time, but the very number of them argues that no one of them is of any special use. Barker recommends that the limb be gently rubbed with some anodyne liniment for fifteen or twenty minutes every six hours of the acute stage. The friction should be in the direction of the venous flow. When the acute stage is passed a plain flannel roller bandage should be put on and reapplied until the swelling has disappeared.

For fear of a dislodgment of a clot and the consequent pulmonary embolism the limb should handled as little as possible and the patient should not be allowed to get out of bed until the clots have all disappeared or become thoroughly organized.

The treatment of pyæmic abscesses when they occur has already been spoken of.

PLACENTA PREVIA.*

BY J. S. KNOX, M. D., OF CHICAGO.

Mr. President, five cases of placenta previa have come under my observation, and I would like to make a few deductions from them.

The first case was a central implantation, profuse haemorrhage occurring at the completion of the sixth month. I was called in consultation by the physician in charge and found that he had applied a tampon. The woman was almost exsanguinated from loss of blood, and the pains were strong and expulsive. The tampon had been in three hours, and I was satisfied from the character of the pains that the os must be, to some extent, dilated and that delivery would be proper. Rapidly taking out the tampon, I was able to get two fingers through the os, passing directly through the placenta, and found the feet presenting. I seized the feet and made the extraction without difficulty. The placenta came readily

away. The woman was so utterly feeble and almost pulseless that no attempt was made to disinfect the uterine cavity or the vagina, but she was freely stimulated. She made a slow but satisfactory recovery, without evidence of septic infection.

The second case was a patient of my own, living on Washington Boulevard. It was a second pregnancy following a first confinement within three months. At the sixth month of gestation she had a haemorrhage while asleep in bed, which awakened a suspicion in my mind of placenta previa. A careful examination confirmed the suspicion, and Dr. Miller, who saw the case with me, made the same diagnosis. I secured a Braun's colpeurynter, and, getting a competent nurse from the hospital, instructed her in its use and determined to let the woman go to the seventh month. A second haemorrhage occurred two weeks after the first, which ceased almost as soon as it came. The colpeurynter was used, but discontinued after an hour or two. She remained in bed for two weeks, when she again had a profuse haemorrhage. The nurse was with her and used the colpeurynter, which was left *in situ* for nearly thirty-six hours. It brought on labor, and when I was satisfied that delivery could be accomplished, Dr. Earle was called in to assist. We collapsed the colpeurynter, and I introduced my hand and found the bag of waters presenting. I ruptured it and succeeded in introduction of the forceps and rapidly delivering. A living child was extracted, and it lived twenty-four hours, when haemorrhage occurred at the cord. Every effort was made to save the child's life, but it died of the haemorrhage. In this case the uterus was thoroughly washed out and the woman put on fluid extract of ergot for two weeks. She made a satisfactory recovery. I saw her subsequent to her recovery, found a double laceration of the cervix, and repaired it.

The third case was one of central implantation. The first haemorrhage occurred at the end of the sixth month of gestation, the day after I saw the case I have just

*Read before the Gynæcological Society of Chicago, February 21, 1890.

reported. I was very suspicious, of course, and made a very careful examination. Dr. John A. Robison, who lived near by, was called in and agreed with my diagnosis. The husband, a very intelligent man, was instructed how to use the colpeurynter, and I determined to let the woman go to seven months of gestation in order to save the child, if possible. No further haemorrhage until the seventh month, when, while walking about the floor, she had a gush of blood. The husband, being present, placed her on the bed and, introducing the colpeurynter, inflated it with his mouth. I found it well distended, but increased the distention of the bag and left it in for twenty-four hours. The urine had to be drawn, and the bowels were pretty well pressed upon. The woman suffered considerably and was given morphine hypodermically. At the end of twenty-four hours she had expulsive pains, the colpeurynter was pressed down on the vulva, and I thought it time to deliver. In this case I had to tear off the placenta; finding a transverse presentation, I delivered by the feet. The child was born alive and lived for nearly thirty-six hours.

The fourth case I saw in consultation with Dr. Davis. He came to me in the night, stating that he had been called to a woman with a severe hemorrhage, that she was seven months pregnant, and that he suspected placenta previa. When I got there I found the woman pretty well exhausted. The tampon was reinforced and Dr. Davis and I stayed three or four hours, until we were satisfied delivery could be accomplished. He introduced a hand into the vagina, and, tearing away a portion of the placenta, reached the feet of the child, turned and delivered it. The woman was so exhausted that we thought it best not to use any after-treatment except to save life. She was given hypodermatic injections of whiskey, ergot, and opium. She made a satisfactory recovery.

The fifth case was a marginal implantation. The woman went through eight

months of pregnancy, and in the first week of the ninth month was taken with sudden hemorrhage. I made a careful digital examination, but found no evidence of placenta previa. About a week afterwards she had a second and severe haemorrhage, and a neighboring physician who was called immediately introduced a tampon. I was sent for, and finding the tampon incomplete reinforced it, packing the vagina full of borated cotton. The tampon was left in thirty-six hours. It brought on labor, and I concluded to remove it. I was glad to find the os dilated, the membranes ruptured, and the head engaged in the superior strait, arresting hemorrhage. This woman had a previous bad history of delivery; this was her third pregnancy occurring in three years. The first delivery was artificial, mutilation of the child being done in order to accomplish its extraction. Her second labor came under my observation. She had an occipito-posterior presentation, and, remembering Dr. Sawyer's suggestion, I rotated the occiput forward several times, but every pain would replace it, and at last I concluded the only thing to do was to try forceps. I rotated the head forward again, applied the forceps, and extracted the head with the occiput under the symphysis pubis. The child was evidently injured by the forced rotation; it commenced to bleed freely from the ears, and died in a few hours. In this third labor the woman went eight months and a week. After the tampon was removed she made no further progress, although every effort was made to encourage delivery, and finally the forceps were put on and delivery accomplished. She had a miserable laceration of the cervix, which I intend to repair. In this case no attempt was made at washing out the uterine cavity; the vagina was kept disinfected, and the woman made a good recovery.

This is too small a number of cases of placenta previa to base conclusions upon. I simply wish to call attention to four items. The first of these is the great mortality of children in placenta previa.

In two of these cases the placenta previa was detected early and every precaution was used to continue the pregnancy up to the seventh month. In both cases delivery was made of living children. One child died from purpura hæmorrhagica at the end of twenty-four hours—a persistent hæmorrhage of blood which refused to clot, although every effort was made to arrest it. The other child died of exhaustion. After diagnosis of placenta previa is made, I doubt the wisdom of prolonging the gestation in the forlorn hope of securing the life of the child.

The second item I would call attention to is the immunity of these few women from sepsis. With a deep implantation of the placenta, with torn uterine sinuses, with the probable introduction of septic material into the uterine cavity of each, and antiseptic treatment adopted with but two, still not one of the five presented the slightest evidence of sepsis.

The third point I would call attention to is the value of the colpeurynter. This was used in two cases. I doubt if it is possible, in the emergency of hæmorrhage from placenta previa, to otherwise properly tampon the vagina. The hæmorrhage is too profuse and the haste required too great. In addition there is a risk of sepsis being introduced with these hasty tampons. On the other hand, it is the simplest thing in the world to slip the collapsed bag into the vagina and inflate it. In addition to the ease with which it is introduced, I would call attention to the complete manner in which it arrested hæmorrhage; the elastic rubber bag fitted close to the walls, and it gave as little pain as any tampon could. It is removable almost instantaneously, and I think it is *par excellence* the tampon for placenta previa.

The fourth point I would make is the cause, as far as these cases show, of this deep implantation of the placenta. The first patient, the doctor told me, had had one pregnancy, one miscarriage, and a second pregnancy in thirteen months;

the uterus was kept constantly at work and no opportunity given for the full repair and healthy condition of its mucous lining. In the second case I had delivered the woman but nine months before she had her second child. Thus impregnation had occurred two months after the instrumental delivery of the child and the tedious getting-up of the woman. In the third case I have always confined the lady, and she has had five deliveries, one miscarriage at four months and one at six months, and has not been married eight years, so that her uterus has been constantly active. The fourth case, the one occurring in the practice of Dr. Davis, was a first pregnancy. In the fifth case there had been three deliveries, all artificial, all painful, all occurring in three years. So I should say that frequency of functional activity and imperfect repair of the uterus is a common cause of placenta previa.

The fifth point I would make is that forcible delivery and the peculiar condition of the internal os almost necessitate cervical laceration. All five suffered from this accident. I have a case at present in the Presbyterian Hospital, a lady who was delivered by another physician seven years ago, under placenta previa. She came to me for operation. I found a double laceration of the cervix opening up to the internal os. In every case that has come under my observation there have been one or two lacerations due to the anatomical condition and the forced delivery of the woman.

FOUR CASES OF PUNCTURED FRACTURE OF THE CRANIUM. ONE CASE OF PENETRATING PISTOL-SHOT WOUND OF THE CRANIUM.

BY J. W. CHAMBERS, M. D.,
OF BALTIMORE.

Mr. President and Gentlemen:—The progress of knowledge in the matter of

*Read before the Medical and Chirurgical Faculty of Maryland, at its 91st Annual Session, April 22nd, 1890.

cranial surgery, and the keen interest in the attempts to institute operative procedures for injuries to the cranium and its contents, are the bases for my venture to report in the following paper, the limited series of cases of injuries to the brain, that have come under my personal care during the past six months.

I have to report four cases of punctured fracture of the cranium, and one penetrating pistol-shot wound of the cranium, all terminating in recovery.

Case I. Penetrating pistol shot wound of the cranium. Ball within cranial cavity. Drainage. Recovery. I. H. Male; colored. Brought to the City Hospital Sept. 11th, 89, at 5 P. M., suffering with a pistol-shot wound, (38 caliber) in the left temporal region. He walked from the station house to the hospital, (a distance of two squares) assisted by a police officer. Was not suffering with any marked shock. The patient was at once placed in bed, and the necessary care given by the house physician Dr. Smith. The head was shaved, thoroughly cleansed with soap and water, then washed with 1-2000 solution of bichloride of mercury. A pad of absorbent cotton soaked in a solution of bichloride, was placed over the wound, and the patient was given $\frac{1}{4}$ grain of morphine. No further treatment was given until the next morning. Sept. 12th, 10 A. M., patient irritable and restless, can with difficulty be sufficiently aroused to answer questions, and readily relapses into a semi-unconscious condition. Temperature 99°, pulse 100, respiration 20. Pupils contracted, but respond to light. Reflexes increased. No paralysis or twitching of muscles. The patient was given $\frac{1}{4}$ grain of morphine hypodermically, chloroformed, and placed upon the operating table before the class. The point of entrance of the ball was $1\frac{1}{4}$ inches behind and $\frac{1}{2}$ inch above the external angle of the eye. This wound was freely enlarged, and a corresponding wound of the cranium exposed, which proved to be a very abrupt punctured fracture. The edges of the bone next the angle of the eye being quite perpendicular. The

amount of depression was $\frac{1}{2}$ inch, driving a small central piece of bone into the cranial cavity. The $\frac{1}{2}$ inch trephine was used, and the broken fragments of bone removed, leaving an opening $1\frac{1}{4}$ by $\frac{3}{4}$ of inch in extent. The dura mater was perforated, covered by a clot of blood, very tense, and bulged into the opening. Pulsation was absent, on slitting up the dura, an ounce of clotted blood, and broken down brain tissue welled up. After washing away this substance with a gentle stream of warm 1-4000 solution of bichloride, a grooved director was gently passed into the bullet tract, which extended into the brain $4\frac{1}{2}$ inches inwards, obliquely backwards, and upwards. The ball was not detected, and as there were no symptoms to indicate its probable location, no further search was made. A rubber drainage pipe was inserted four inches into the wounded track of the brain, and a hot solution of 1-4000 bichloride injected. The wound of the soft part was accurately brought together around the drainage tube, and secured by five silk sutures. After well dusting the wound with iodoform, a large pad of borated cotton supported by a bandage applied with considerable pressure, completed the dressing. The patient rallied from the anaesthetic in an hour's time, and was able to answer questions intelligently. Took milk and ice freely, and was free from pain. On the evening of the day of operation, there was some restlessness and slight vomiting, the result of chloroform. The subsequent history of the case is comparatively uneventful. The wound was not disturbed until the 14th, after operation, when it was found to be perfectly healed throughout, except at the point of the drainage tube. Not the slightest irritation was visible at the point of sutures. They were removed, the drainage tube withdrawn two inches and cut off. The dressing was renewed October 7th., and the drainage tube entirely removed. The wound rapidly healed, and the patient was discharged from the hospital, cured, October 27th. I saw him a few days ago,

and he was to all appearances in perfect health.

CASE II.—A case of punctured wound of the skull, trephined; recovery.

John E. Gurns, a blacksmith, æt. 28, was admitted to the City Hospital Nov. 5th. While engaged in an election fight, he was struck on the head with a brick, making a Y-shaped scalp wound, about two inches in length, situated rather below and behind the middle of the left parietal bone. The head was shaven, cleansed with soap and water, then washed with a solution of bichloride of mercury. A large pad of absorbent cotton soaked in a solution of bichloride, was placed over the injured part, and retained by a roller bandage. Patient put to bed and given morphia sulphate, $\frac{1}{8}$ grain hypodermatically. The man was but little affected by the injury after its immediate effects had passed off (which lasted one hour), and had no idea of its serious nature. He rested well during the night. At 11 A. M., November 6, sixteen hours after receiving the injury, the patient was again given $\frac{1}{8}$ grain of morphia hypodermatically, and chloroformed. On freely enlarging the scalp wound, a Y-shaped fracture of the parietal bone was exposed, with its center depressed $\frac{1}{2}$ inch. The sides of the fracture sloped evenly towards the central and most depressed point. A half inch trephine was used, and several fragments of bone removed. They, with the button, left a space where bone was wanting $1\frac{1}{2}$ by 1 inch. The dura, covered by a thin blood-clot, bulged into the wound and pulsated. The clot was thoroughly washed away with a hot solution of 1-4000 bichloride of mercury. This started fresh bleeding from one of the middle meningeal arteries, which was controlled by passing a threaded needle under it and ligating. The wound was well washed with a solution of bichloride, cat-gut drainage used, dusted with iodoform, and closed with silk sutures. A large compress of borated cotton, supported by a rather tightly applied roller

bandage, completed the dressing. The amount of shock was very slight. Was placed on a light diet. Wound redressed November 18th, twelve days after the operation, and stitches removed. A linear cicatrix remained to mark the site of the wound. The temperature was normal throughout the convalescence, and no signs of constitutional disturbance whatever were present, unless an accelerated pulse, which was noted during the recovery of all cases reported, might be so considered. The patient was discharged on the 22nd day of December—to use his own words—"feeling as well as he ever felt in his life." The local and constitutional progress of this case could not have been more favorable. When I saw him the other day, four months after the injury, he told me that he had enjoyed perfect health continuously since his discharge from the hospital.

CASE III.—A case of depressed fracture of the cranium. Trephined. Recovery. Wm. Grump, æt. 17, white, laborer, fell from elevation of thirty feet, was picked up in an unconscious condition. Rapidly regained consciousness, so that when brought to the City Hospital one hour afterwards, he answered questions slowly but intelligently. On examination there was found to be a lacerated wound of the anterior part of left parietal region of scalp. The head was shaven, and thoroughly cleansed with soap and water, then washed with a solution of 1-1000 bichloride of mercury. A pad of absorbent cotton wet with a solution of 1-2000 bichloride was bandaged over the wound. Four hours after the accident, the patient was given a hypodermic injection of morphia, and chloroformed. On enlarging the scalp wound, a depressed fracture $2\frac{1}{2}$ by 2 inches of the anterior portion of the parietal bone was observed. The $\frac{1}{2}$ inch trephine was used. The depressed bone elevated, and several fragments removed. The dura mater bulged into the wound, was covered with a large blood-clot, and pulsated.

The removal of this clot gave rise to a severe haemorrhage from a lacerated branch of the middle meningeal artery. This haemorrhage was, with considerable difficulty, controlled by passing a ligature around the branch, by means of a specially curved needle. The wound was then washed with a solution of bichloride, cat-gut drainage used, and dusted with iodoform. A large pad of borated cotton, retained by a roller bandage completed the dressing. The patient was severely shocked, but in two hours rallied to a complete recognition of his surroundings. Was ordered a light diet, and no drugs to be used unless specially indicated. At 6 P. M., the day of operation, the temperature was 100°, pulse 98. Patient rested well during the night and at no other time during his stay in the hospital, did his temperature range above 99°. On the removal of the dressing, the 14th day, the wounded soft parts were found to have entirely healed, except a small amount of granulation at the lower angle of the wound. The stitches were removed, the parts dusted with iodoform, and a pad of borated cotton again applied. Patient left the hospital Jan. 2nd, fully recovered from the effects of his injury.

CASE IV.—A case of punctured fracture of skull. Trephined. Recovery. W. L. Denby, at. 47, white, male, occupation that of a bricklayer. Fell December 27th, fifty feet from a scaffold. Was immediately brought to the City Hospital in an unconscious condition. On examination, a V-shaped wound of the scalp, just above the left frontal eminence, and half an inch to the left of the median line was observed. Also several abrasions and scratch wounds. The head was shaven, the wounds thoroughly washed with an antiseptic solution, dusted with iodoform, and covered with borated cotton. The patient was then placed in bed. For the next few hours he was very restless, and still unconscious.

At 6 P. M. on the day of accident the temperature was 100°, the pulse 68, 11 A. M. December 28th, (the day follow-

ing accident), the patient was fully conscious, but complaining of head-ache. While answering all questions intelligently, he had no knowledge of what had passed since the accident. There were no symptoms of compression present. Being still in doubt as to the real nature of the injury of the head, a second examination of the scalp wound was made, and the fracture detected. The patient was immediately given a hypodermic injection of morphia, chloroformed, and placed upon the operating table. On enlarging the scalp wound, the punctured portion of the bone was thoroughly exposed. This fractured portion was found to be tilted and depressed. The trephine was used, the depressed portion elevated, and several fragments removed. The dura matter had been punctured, and was covered with a considerable blood clot. Upon washing away this clot, quite a free haemorrhage ensued from an injured vessel of the dura, which was ligated. The wound was washed with a hot solution of bichloride, cat-gut drainage used, dusted with iodoform, and scalp brought together with silk sutures. A pad of borated cotton, retained by a tightly applied roller bandage completed the dressing. The patient was very little shocked from the operation. At 6,30 P. M., December 28th, the temperature was 100.5°, pulse 85. There was no head-ache. He felt comfortable, and was resting well. December 29th at 8 A. M., the temperature was 100°, pulse 80, and resting comfortably. At no subsequent time during his stay in the hospital, did the temperature range above 99°. The dressing and sutures were removed on the 15th day, as the wound was entirely healed. The general condition of the patient was good. He left the hospital entirely well, January 31st.

CASE V.—A punctured fracture of the skull. Trephined, Recovery. W. H. at. 35. White, Male. Occupation that of ship-carpenetr. Fell fifteen feet down hatchway of a vessel. I saw him in consultation with Dr. C. P. Strauss

March 23rd., four hours after the occurrence of the accident. On examination found an irregular lacerated wound of the scalp, over the superior posterior portion of the parietal bone, leading down to a punctured fracture of same, also a Colles's fracture of the left fore-arm. The patient was dull and heavy, and answered all questions in monosyllables. The temperature was 99°, pulse 60, and full. After shaving the head, thoroughly cleansing it with a solution of chloride, a hypodermic of morphine was given, and the patient chloroformed. The $\frac{1}{2}$ inch trephine was used, and a number of fragments of the bone removed. One of these having punctured the dura-mater and pia mater, giving rise to a severe haemorrhage from a wounded vessel of the pia mater, a ligature was passed around this vessel by means of a specially curved needle, all hemorrhage controlled.

The wound was washed with a 1-4000 solution of bichloride, cat-gut drainage used, dusted with iodoform, and covered with a large pad of borated cotton, held in place by a snugly fitting roller bandage. The patient was considerably shocked after the operation, but rallied during the next four hours. There was some vomiting from the chloroform. The dressing was removed on the 7th, day, and as the wound was found to be healed, the stitches were removed. Twenty days after the operation, the patient was well and about his room.

The small number of cases which I have brought before you, are not expected to definitely settle any conclusion in reference to brain, or other injurics to the skull. For with exception of the first case related, there is but little doubt but that the brain largely escaped any very severe primary injury. There is however, one fact on which I should like to lay stress; viz: that the operation of trephining is not a dangerous one. The operation of trephining should be done, not so much for the elevation of depressed bone, but for the removal of a foreign body, which may at any moment light up an inflammation of the delicate structures

beneath which, although readily started, is difficult to arrest.

To the general surgical rule of immediate reduction, which is so universally accepted for all fractures of other bones, there is no sound surgical reason for making the bones of the head the exception to the universal rule of immediate reduction.

309 North Exeter Street.

Society Reports.

CLINICAL SOCIETY OF MARYLAND.

The 232nd meeting of the Clinical Society of Maryland was called to order April 4th by the Vice-President, Dr. Wm. H. Norris in the chair.

Dr. George H. Rohé read a paper on the

MUTUAL RELATIONS OF THE MEDICAL PROFESSION AND THE HEALTH DEPARTMENT.

In the paper Dr. Rohé cited the law regulating the reports to be made of deaths, births and contagious diseases, and called attention to the value of such statistics being accurately kept. He urged that the profession do its whole duty in regard to the matter.

Dr. John D. Blake said that he was in perfect accord with Dr. Rohé in reference to the value of such statistics and thought that the profession should do its part in aiding them to be accurately kept. While it is well that such should be the case, we find that more is required than merely the reports of physicians. When a report of a contagious disease is made an investigation is authorized by the Health Department. But those investigations are not always scientific; sanitary inspectors are often men entirely disqualified for such positions. In order that the work must be scientifically done we

must have more competent men as sanitary inspectors.

Dr. Joseph T. Smith said that he was very glad that Dr. Rohé had brought out this paper calling attention to the report of contagious diseases. In sending us these reports the family often becomes seriously alarmed, and sometimes it no doubt does harm. It is hard to make this part of the law practical in value unless we have ideal inspectors. He hopes to see this reform take place.

Dr. J. Edwin Michael said that he partook universally to the idea brought forward by Dr. Rohé, and he was glad that he was going to carry out the law in reference to the matter.

Dr. A. K. Bond asked if similar laws had been strictly enforced in other cities?

Dr. M. B. Billingslea suggested that a copy of the report made by the Sanitary Inspector be mailed to the physician who is in attendance at the time.

Dr. George H. Rohé said in other cities the law is carried out more arbitrarily than it is here. He thanked the members for the interest they had taken in the subject, and hoped that the profession would do its part in lending him all their aid in carrying out the law bearing on this matter.

Dr. John N. Mackenzie talked on

POST-NASAL OBSTRUCTION IN CHILDHOOD.

He said that nearly all nasal obstruction in children is post-nasal. Besides the congenital causes, the most common one is enlargement of the pharyngeal tonsil. This condition is quite common and grows with great rapidity in early childhood. At puberty it undergoes a retrograde metamorphosis. It is a very frequent affection in the city. He then spoke of the symptoms and treatment, advising its removal as the best method. He exhibited a forceps, which, when introduced into the naso-pharynx, readily seizes the growth and brings it away.

Dr. H. Clinton McSherry said this subject was very interesting and well deserved the attention that Dr. Mackenzie had

given to it. It is a condition that brings on various symptoms, viz; headache, stupidity, many reflex troubles and often interference with the general health. In reference to their removal this may be said: when we have a small faucial tonsil it is hardly necessary to take it away and the same may be said of the pharyngeal tonsil. If it presses on anything an operation is necessary. It is well not to act too soon. The best method for their removal is by use of forceps. Sometimes after the operation extensive and occasionally alarming hemorrhage may take place.

Dr. John N. Mackenzie said that he did not go into details concerning these growths and for that reason much was omitted that might have been said. Extensive hemorrhage is very rare and little fear may be had from that source. There is hardly a day that he does not operate and always with great relief to the patient.

W. J. JONES, M. D., Sec'y,
1238 Greenmount Ave.

FORMULA FOR THE HYPODERMIC ADMINISTRATION OF ERGOTININ

Baroni uses the following formula for the hypodermic administration of ergotinin:

B—Ergotinin	}	3 grains.
Lactic acid		
Cherry-laurel water		

Distilled water 3 drachms.
 3 ounces.

—M. The dose of this is from fourteen to eighteen drops.—*Gazette de Gynécologie*.—*Medical News*.

Dr. Warburg, the inventor of the “tincture” of anti-malarial renown, is said to have reached the age of 86 years, and to be in great pecuniary distress. An appeal on his behalf has been published in England.

MARYLAND MEDICAL JOURNAL

Weekly Journal of Medicine and Surgery.

WILLIAM B. CANFIELD, A.M., M.D., Editor

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BALTIMORE, JULY 19, 1890.

Editorial.**THE RECENT EPIDEMIC OF RUBELLA.**

According to the records of the Baltimore Health Office there has been quite an epidemic of measles in the city during the current year. To those who are informed upon the subject it is quite clear that a large proportion, perhaps half, of these cases reported as measles have not been clear cases of that disease at all, but have belonged to the disease or group of diseases to which the names "Rubella," "Rötheln" and "Epidemic Roseola" have been applied by different writers.

The best authorities hold that cases of this sort have no connection with measles nor with scarlatina, since previous attacks

of measles and scarlatina do not produce immunity, even for a single month, against the milder diseases now under discussion.

These cases, thus known as "Rubella" etc., present the common characteristics of a febrile eruptive disease, lasting generally less than a week, requiring little or no treatment, interfering very little with the comfort of the patient and leaving him with no bodily disorder save perhaps a mild bronchitis. The various eruptions with all their differences of form, distribution and intensity may be readily grouped into two classes—the punctate and the erythematous. Cases of the punctate class may have the points of redness scattered irregularly over the surface or grouped into circles or semi-circles, with little or no redness of the surrounding skin. They are generally mistaken for measles, which they resemble very closely except in their uniform mildness. It is safe to say that at least half of the cases called measles occurring recently in Baltimore were instances of this form of disease. This form occurred as an epidemic in a Children's Home in this city, affecting from 20 to 40 of the inmates, some of whom had in recent years had measles, but presenting in no instance the serious symptoms observed in measles, and requiring no active treatment. If it had been true measles there would almost certainly have been some severe cases among such a number of patients.

In the erythematous form there is a diffused redness of the surface which causes the erroneous diagnosis of "scarlatina." Apart from the rash, however, there is no symptom which points to scarlatina.

That the punctate and erythematous

forms belong to the same disease is probable, because the duration and severity of the affection is the same in both, because both present a mild catarrh of the respiratory tract, and because a patient may present the punctate form and a week or two weeks later may present, in a relapse, the erythematous form of eruption. Moreover, there are in each epidemic cases which present in varying proportions both the dots and the erythema.

She subject has been thoroughly discussed under the title "Rubella" by Dr. I. E. Atkinson in the *Amer. Journ. Med. Sciences*, Jan. 1st, 1887.

Whether, from the, at present, confused mass of unclassified mild eruptive fevers other distinct diseases will be hereafter isolated and named, remains to be seen. It is certain that such fevers deserve more careful study than they have yet received. If they are abortive forms of well known diseases dangerous to life this fact should be known. If they are distinct and harmless diseases, the patient should not be frightened and statistics vitiated by the use of the titles "measles" and "scarlatina."

TENOTOMY TO INCREASE THE MOBILITY AND POWER OF THE MUSICIANS' RING-FINGER.

In the early drudgery of piano playing the pupil always has the task imposed of playing an exercise that will strengthen the third finger. That little force can be exerted by this finger while the other fingers are in contact with the keys of the instrument is well known to beginners, but few have understood the reason,

Dr. F. W. Langdon (*Cincinnati Lancet-Clinic*, July 5, 1890,) describes the operation which he has performed to make the third finger move with strength and independently of its neighbors. The principle of the operation is the division of certain tendinous slips or "guy ropes" which bind the third finger intimately with its neighbors. As there seems to be no reason for the anatomical relation, the author supposes it is "one of the useless legacies transmitted to us from a remote ancestry." Whatever the explanation may be, Dr. Langdon reports a case with successful and satisfactory results, and summarizes as follows:

1. That division of one or both of the diagonal tendinous slips, connecting the extensor tendon of the ring-finger, with those of the middle and little fingers, is a simple and almost painless procedure, which is followed by marked improvement in range of motion vertically and laterally, of the three inner fingers.

2. That this improved mobility is especially notable and important in the case of the ring-finger; and that the usefulness of this digit to the musician is greatly augmented at once.

3. Owing to increased functional activity permitted in the muscular fibres acting on this digit, progressive development in power may be expected to follow.

Correspondence.

A CORRECTION.

Editor Maryland Medical Journal:

DEAR SIR:—In your recent editorial on the treatment of diarrhoea in early life, in the issue of July 5th, 1890, you have

done me the honor to quote some of my observations on sterilized milk. Will you allow me to correct one misapprehension that inadvertently crept into the editorial? As a result of a series of experiments performed by adding various reagents to cows' and human milk, both plain and sterilized, I found that larger and more confluent curds were formed in plain milk than in sterilized milk. The prolonged heat necessary for sterilization has a tendency to make the caseine coagulate in smaller clots, but there is still a very appreciable difference in the clot of cows' and human milk.

Yours Respectfully,

HENRY D. CHAPIN, M. D.

27 West 51st Street, New York.

AN INQUIRY.

Editor Maryland Medical Journal:

DEAR SIR:—I should like to inquire through your JOURNAL what is the status of the "Baltimore University" with regard to the movement in favor of higher medical education? All the other schools here have joined it, apparently in good faith.

Yours Truly,

EUGENE F. CORDELL, M. D.
2111 Maryland Avenue.

[Probably a member of their faculty will reply:—ED.]

Reviews, Books and Pamphlets.

Transactions of the Southern Surgical and Gynaecological Association. Volume II. Second Session, held at Nashville, Tenn., Nov. 12, 13 and 14, 1889. Published by the Association.

The size and character of the second volume of this Association reflect great credit on the South. This Association

was founded one year ago and the volume contains original articles and discussions which even a hasty glance shows to be of a very high order. Most of the names are those of men with reputation, and several in the list of members are from Northern cities. Many of the articles are short, containing a relation of facts; some show evidence of research. The volume is well printed and neatly bound.

A Lecture on Sexual Perversion, Satyriasis and Nymphomania. By G. FRANK LYDSTON, M. D., Chicago. Reprint from *Philadelphia Medical and Surgical Reporter*.

Two Cases of Resection of the Caecum for Carcinoma, with Remarks on Intestinal Anastomosis in the Ileo-Caecal Region. By N. SENN, M. D., Ph. D., Milwaukee. Reprinted from the *Journal of the American Medical Association*.

Climatology and Diseases of Southern California. By F. D. BULLARD, A. M., M. D. Reprinted from the *Southern California Practitioner*.

Mr. Bernard Hollander, of London, will contribute to *The Popular Science Monthly* for August an illustrated paper on "Centers of Ideation in the Brain." It will show how the experiments of modern physiologists support some of the observations of the early phrenologists, though by no means indorsing all that the name phrenology implies.

Among the articles announced which promise to make the August *Popular Science Monthly* an interesting and timely number are "Thunder Storms," by Robert H. Scott; "A Queer Pet," by Miss E. W. Bellamy; and "The Uses of Animal Color," by Edward B. Poulton.

The July number of *The National Magazine* of Chicago will open with an article entitled "Harvard University and Reform," by Chancellor Harkins of the

National University of Chicago, in which the wisdom of President Eliot's radical recommendations is forcibly maintained. Other timely articles are:—"Plan Proposed for a Polytechnic Institute," "Biblical Literature," by Rev J. C. Quinn, LL. D., "College Courses for Non-Residents," "Union College Examinations" and "Honorary Degrees." Young men will be interested in the article on the "Chicago Trade Schools." Particulars of the recent gift of twenty-five acres of land near Chicago, worth \$25,000, to the National University and of its proposed new building thereon are also given in this number. Published at No. 147 Throop Street, Chicago, Ill. Sample copy, 10 cents.

Miscellany.

THE COLOUR OF NEGRO INFANTS.

Several histologists of authority, including Kölliker, have taught that the skin of the negro infant is not pigmented at birth, although the colour distinctive of the race is rapidly developed in the course of the first few weeks of extrauterine life. In Europe the chances of observing a large series of pure-bred infants are rare. In the United States it is otherwise. Dr. Morison, of Baltimore, has made use of his opportunities of observation, and has shown, in consequence, that the current opinion as to the complexion of the negro at birth is quite erroneous. He examined the skin of the arm of an eight month's foetus whose father was a negro, and mother moderately dark-complexioned. Pigment was found in the lowest layers of the rete mucosum. He also detected pigment in the skin of a mulatto child who had died about thirty-six hours before birth. Dr. Bowen, writing in the *Boston Medical and Surgical Journal*, on Dr. Morison's researches, adds a notice of his own observations. A few years ago he enjoyed the opportunity of inspecting, at the Boston Lying-in Hospital, a considerable

number of negro and half-caste children at, or soon after, birth. The colour of the skin was found to vary within a wide range. The pigmentation was marked from the first in all cases where the skin of the parents was very dark. The old, or European, opinion is true of infants with a considerable infusion of white blood. They are white-skinned at birth, but pigment is deposited in the rete mucosum within a few days.—*British Medical Journal*.

HINTS TO THE UNFORTUNATE.

A few suggestions, culled from accounts in the daily press, of cases, of "accidental death" during the past week, may prove of service to those who are not ingenious enough to think of them for themselves: (1) Mix some coarse flour and strychnine to kill the rats with, then place the mixture in a jar, similar and as near as possible to the containing the family oatmeal. Prepare to shed this mortal coil! (2) Place some laudanum in an empty medicine bottle, and stand it alongside a bottle of physic on a table by your bed-side; take a dose, from the nearest bottle, in the dark; ten chances to one it's the laudanum. (3) Pour some carbolic acid into a beer-bottle, cork it, and put it aside in a cool spot; the next person who comes along with "a mouth on him," will find it a vast improvement on common or ginger beer. (4) Smear a piece of bread with phosphorus paste (rough on rats) and leave it in a cupboard well within reach of marauding youngsters; if their lives are insured, you will have no reason to regret the experiment.—*Hospital Gazette*.

AN ANTISEPTIC FOR MIDWIVES.

The Paris correspondent of the *Pharmaceutical Era* writes that the Academy of Medicine has formulated the following antiseptic powder to be dispensed to midwives, upon their order in writing:

Corrosive sublimate.	3.8 grs.
Tartaric acid,	15.4 "

Five per cent. solution of indigo-carmine, 1 drop
Mix and dry.

Each powder to be dissolved in one quart of water, must bear the regulation orange-red label, with the words "Corrosive Sublimate. Poison."—*Med. News.*

RAISING THE EPIGLOTTIS.

A Vienna correspondent of the *Southern Medical Record* says that Dr. L. P. Preston, of Lynchburg Va., after many efforts to find the easiest mode of raising the epiglottis for operative purposes, struck upon the happy thought to press upon the middle glosso-epiglottic ligament, when to his great gratification the epiglottis reared as though spurred, and a full view of the upper air passages were obtained. This method has met with great favor with Professor Schrötter and his assistants.—*Northwestern Lancet.*

EXPERIMENTS ON THE MOTOR AREAS IN THE BRAIN OF THE ORANG-OUTANG.

Dr. Beevor and Mr. Victor Horsley have recently communicated to the Royal Society an account of the investigation which they have concluded on the excitable portions of the brain of the orang-outang. This animal was selected owing to the fact that its brain approaches the human type more closely than the brains of other monkeys. The exposed cortex was mapped into little areas two millimetres square, and each of these was stimulated by a minimal induced current, the current required being much stronger than in the investigators' previous experiments on the bonnet monkey (*Macacus sinicus*). As the result of these observations they found the excitable regions of the cortex to occupy much the same position as in the bonnet monkey, and that the various parts of the body (face, arm, &c.,) were represented in the cortex in much the same plan as in the lower species. It was observed, however, that in the orang-outang the representation of

each limb and segment was much more clearly differentiated, so that stimulation of one point rarely produced more than one movement, and that of one segment, as, for instance, flexion of the elbow. Frequently around one of these "motor areas" would be a zone of inexcitable cortex, thus marking off one area very definitely from the next. Probably in man a similar condition holds, judging from the effects of the electrical exploration of the human cortex for diagnostic purposes in a few published cases in this country and in America. Dr. Beevor and Mr. Horsley also exposed and stimulated the internal capsule in the orang-outang, and found that the fibres from the different parts of the cortex have exactly the same relations as in the bonnet monkey. An abstract of their observations on this animal was recorded in the *Lancet* of December 28th, 1889.—*Lancet.*

PHENACETIN IN TYPHOID FEVER.

Dr. Sommer has used phenacetin with great success in the treatment of typhoid fever, thus confirming the favorable views of its action which has been expressed by Masius and others. The dose employed for adults was four grains, which was repeated from two to four times during the twenty-four hours. Children were given only half this dose. No less than sixty cases were treated in this way, with but one fatal case, about which it is noted that the patient was not subjected to the phenacetin treatment until three weeks from the commencement of the attack. In no case were there any serious complications.—*Lancet.*

THE UNCERTAINTY OF MALPRACTICE SUITS.

How a trifling may turn a jury's view of testimony in a malpractice suit—or, for the matter, in almost any case under trial—is shown in this incident: A surgeon having been sued for malpractice, it was in evidence that he had had on evening dress at the time of doing a minor operation on the plaintiff, and the

doctor's counsel was apprehensive that the jury would infer from this fact that he was in haste to get away to the opera or some other entertainment, and therefore negligent of his patient. It happened, however, that a little Irishman on the jury, having found that this inference had actually been drawn by his fellow jurymen, assured them that they were all wrong, saying that he knew something about surgeons' customs, as he had a relative in the profession, and that one of them used to put on full dress whenever an operation was to be performed. This statement turned the tide and the verdict was in the doctor's favor.—*New York Medical Journal.*

BERLIN MEDICAL CONGRESS.

The surgical section has agreed to assemble for the first meeting on Tuesday, Aug. 5th. The meetings will be held in the chief building close to the station Lehrter Bahnhof. Professor Ollier (Lyons) will read a paper on Surgical Osteogenesis, an Professor König (Göttingen) on Hydrops Tuberculosis of the Peritoneal Cavity. At the second sitting, Mr. Jonathan Hutchinson (London) will read an article on the Surgical Treatment of Intussusception, and Professor Billroth (Vienna) on the Resection of the Stomach and Intestines illustrated by his own practice. At the third meeting Signor Bottini (Pavia) will deliver a lecture on the Treatment of Enlarged Prostate and Mr. Iverson (Copenhagen) on Modern Operations for Cancerous Diseases of the Rectum. On Friday, August 8th, Mr. Senn (Milwaukee) will submit a paper on Gunshot Wounds, and Mr. Lewschin (Kasan) one on Urinary Calculus. At the last meeting of the section Señor Rubio (Madrid) will read a paper on a new method of Excision of the Head of the Femur.—*Lancet.*

TREATMENT OF ACUTE TONSILLITIS.

Dr. E. H. Bidwell of Vineland, N. J. (*Medical Record*, July 5th, 1890) has used the following prescription with great success in acute tonsillitis:—

R. Tinctura guaiaci ammon.,
Tinctura cinchonæ comp. $\frac{1}{2}$ fl. $\frac{3}{4}$ j
Honey, Strained fl. $\frac{3}{4}$ ij
Saturated solution chlorate
of potash fl. $\frac{3}{4}$ xvij

Of this the dose is a teaspoonful every two hours, hour, or half hour, and I generally direct to both "gargle and swallow."

WHAT IS THE MEDICO-LEGAL STATUS OF THE ABDOMINAL SURGEON?

Dr. William Warren Potter of Buffalo, N. Y. (*American Journal of Obstetrics*, July 1890) concludes as follows:

The factors, then, that enter into the inquiry, "What is the medico-legal status of the abdominal surgeon?" and that largely determine that status, may be grouped and summarized as follows:

1. *The Operator's Ability.*—What has been his apprenticeship, what his surgical aptitude, his experience, his fertility of resource—in short, speaking surgically, his abdominal instinct?

2. *The Propriety of the Operation.*—Has this been established beyond reasonable doubt, and have its necessity and dangers been fully explained to the patient and his or her friends; or, in case of minors, to guardians or parents?

3. *The Consent of the Patient.*—Has this been obtained in a legal and binding manner, and have the near friends also consented; and in case of minors have the parents or guardians legally consented, and is there indubitable proof of this?

4. *The Preparation of the Patient.*—Has this been adequately done in accordance with the modern rules of abdominal surgery?

5. *The Anæsthetic.*—What form of this was used, and was the anæsthetizer experienced in the administration of anæsthetics; were the proper precautions taken to determine the relative safety to the patient of the anæsthetic chosen?

6. *The Operation.*—Has it been performed with that skill that the present light of the science would demand?

7. *The After-Treatment.*—Was this in all its details scrupulously and zealously

carried out under the eye of the operator? Was a skilled nurse employed, who faithfully attended to her duties? Did the attending physician yield absolute control to the operator?

8. *The Environment.*—Was the operation done in hospital, public or private, or at the home of the patient?

9. *The Transportation of the Patient.*—Was the patient removed prior or subsequent to the operation? If so, under what circumstances? Was it with the advice and consent of the surgeon and under his superintendence?

On a trial for manslaughter resultant from a disastrous abdominal operation, some or all of these questions would form proper subjects for inquiry by the court, and therefore appear germane to the purposes of this discussion. Doubtless others will be dealt with by the authors who jointly appear in this debate. I will therefore conclude what I have to say in a few brief sentences bearing on the rights of patients and operators:

A patient has the right to refuse operative treatment, however urgent or imperative the need.

After operation the patient has the right to refuse further attendance or treatment from a physician or surgeon who may have been in charge, either as operator or otherwise.

The patient, if sane, has the right to be removed at any time she may elect. Her actions or movements, her acceptance or non-acceptance of a course of treatment by her physician, are matters of her own option, over which he can exercise no legal control. She can go counter to or in accord with his advice, as she may will. He cannot exercise over her person any authority beyond that to which she consents.

For any act of duress the physician could be held legally liable.

In the matter of the husband, his legal control over the wife would not prevent her from submitting to surgical or other treatment at the hands of a physician of her own choice, but with her consent the husband would have the right

to direct or control her movements in the face of any protest of the physician.

The same principles in a modified form apply in cases where there are guardians.

From the foregoing it will be seen that the physician is absolutely helpless in all cases that he cannot reach and control by moral suasion. This places the abdominal surgeon at a peculiarly trying disadvantage, for he is in the rather anomalous position of incurring grave legal responsibilities in cases where he has few legal rights or privileges.

CASE OF HÆMOPHILLIA.

I desire briefly to report a case which occurred in my practice about three years ago, and which is probably worthy of publication by reason of its exceeding rarity. I am unfortunately unable to furnish a complete detail of the same, as I am obliged to give it entirely from memory. At that time I attended a woman in confinement, the labor presented no difficulties, and both mother and boy prospered nicely for a period. On the fourth day, as nearly as I can remember, I was informed that the child had not voided any urine since its birth. This circumstance of course did not alarm me; but to satisfy the family, I made an examination of the genitals at that time. Inspection revealed an occluded condition of the preputial orifice. After some little difficulty I succeeded in insinuating the pointed blade of a pair of scissors between the upper surface of the glans penis and the foreskin, and then slit up this part to a trifling extent. A free gush of urine instantly succeeded; practically no hæmorrhage ensued, and I left the house.

This happened in the forenoon. In the evening I was hastily summoned, and when I arrived the wound was discovered to be bleeding and to have bled profusely, as the napkin was literally drenched in blood. The child's general condition was, however, still good, and indeed continued so for a period of 48 hours. On the fourth day after the operation the

child died. During the interval all available methods were employed to counteract the haemorrhage, but with little success. Vinegar, packing, pressure, etc., were in turn resorted to, with the inevitable result of stanching the blood for a time, but for a time only. It would constantly recur at short intervals. From the time of the operation until its death I must have been with the child one-fourth of the time, trying every experiment that would suggest itself. Dr. E. A. Wood was called in consultation on one occasion. It may be stated that internal remedies, as ergot, gallic acid, etc., even were used, for the ghost of benefit they were likely to afford.

Heredity, we know, is a very important factor in the etiology of haemophilia—the dyscrasia which was of course the cause of my little patient's death, for careful examination failed to discover anything else wrong. No history of the kind, however, was vouchsafed by either the father or mother. Indeed neither of them had ever heard of bleeders before. They were the parents of six children previously, four of whom survive, and of twins subsequently, one of whom, a healthy boy of some 18 months, is still living. The only analogous case to the above that I have found in my reading, is reported at second hand in Erichsen's Surgery. In this instance, however, the prepuce was circumcised.—WALTER STENGEL, M. D., Monroe City, Ind., in *Pittsburg Medical Review* for July, 1890.

CHLORODYNE POISONING THROUGH THE MOTHER'S MILK.

A case is reported in the *Australasian Medical Gazette*, of a woman who had recently given birth to twins and was suckling them both. One evening she took a dose of chlorodyne for the relief of pain, and soon after taking the drug, suckled the infants. The children were found the following morning profoundly narcotized, and died before evening.—*American Druggist*.

Medical Items.

Influenza is said to be epidemic in Iceland. Many fatal cases are reported.

Bellevue Hospital Medical College has adopted a three year's course.

There are said to be 40,321 medical practitioners in Japan. The population is estimated at about forty millions.

The Congress of the French Association for the Advancement of the Sciences will be held at Limoges from August 7 to 14.

Drs. J. G. Van Marter Jr., and A. H. Mann Jr., are at present in Vienna. Dr. Mann, who has been quite ill with typhoid fever, is recovering.

Dr. Bertheraud, director of the *Journal de Médecine et de Pharmacie*, published at Algiers, recently met his death by accidental drowning.

Dr. Frank West who has returned to this city, will attend to Dr. H. H. Biedler's practice during the latter's absence in Europe.

The inmates of the leper hospital at Havana employ their time in the manufacture of bric-a-brac, clothing, etc., which are exposed for public sale.

Surgeon Hamilton, U. S. A., has sailed for Europe to arrange for appointing physicians at all foreign ports to prevent the sailing of diseased emigrants to this country.

Dr. H. R. Winchester, formerly of the Good Samaritan Hospital, has accepted the position of resident physician in the Hospital of the Woman's College, New York.

The Health Department of New York has appointed fifty physicians of the summer corps, and on Wednesday they began

their work among the poor of the tenements.

Dr. Robert Hoffmann will sail for Europe on the *Augusta Victoria*, July 24th, from New York, to attend the International Medical Congress at Berlin. He will return about the first of September.

W. C. Hollopeter, M. D., has been elected Lecturer on Diseases of Children; and Ernest B. Sangree, M. D., Director of the Histological Laboratory in the Medico-Chirurgical College of Philadelphia.

The police authorities of Vienna are making an exhaustive inquiry into a number of questions bearing on the regulation of prostitution. The Professors of syphilology and dermatology are taking an active part in the investigation.

Until Monday July 28th, the Library of the Medical and Chirurgical Faculty will be open only from 12 to 3 o'clock. At other hours physicians desiring nurses for their patients may obtain them at the office of Dr. Townsend, 2122 Pennsylvania Avenue.

The Marchioness of Salisbury opened on April 29th, a bazaar at the New Hospital for Women, Euston Road, London, in aid of the ground-rent fund of the institution. The building is expected to be ready for opening for hospital purposes in the course of a few weeks.

The Dublin Journal of Medical Science for July, 1890, publishes a review of the Transactions of the Medical and Chirurgical Faculty of Maryland for 1889, in which it mentions the work of Dr. W. "Asler" (Osler), and Dr. W. B. "Plant" (Platt). What is fame?

A bill has been introduced into the United States Senate defining "total helplessness" as applying to all persons who lost a leg or an arm at or so near the joint

that an artificial limb cannot be used, and granting all such persons a pension of \$72 per month.

Dr. Pavy was recently presented by the students of Guy's Hospital with a handsome piece of silver plate, on the occasion of his retirement from the office of senior physician. The presentation took place in the anatomical theatre of Guy's Hospital Medical School.

The increase of insanity in Berlin has made it necessary that a new public lunatic asylum should be established. The building, which is to accommodate 1,000 patients, will be situated in the easterly suburb of Lichtenberg. The City of Berlin already maintains an asylum with about 1,200 inmates at Dalldorf.

By the advice of his physician, Dr. William Lee has given up his city practice and moved to the country to live. He has resigned his position as Professor of Diseases of Children in the Baltimore Medical College, and the Faculty of that college has given Dr. Wilmer Brinton that department in addition to his chair of obstetrics.

It is stated that the committee in charge of the J. Marion Sims Fund have closed a contract with a German firm for a full-length bronze figure of the celebrated American gynaecologist. The statue will be completed within a year, and, it is thought, will be placed in Central Park, New York.

The twenty-third annual meeting of the American Otological Society was held on Tuesday, July 15th, at the Hotel Kaaterskill, Catskill Mountains. Papers were read by Drs. C. H. Burnett, A. H. Buck, B. Alexander Randall, F. M. Wilson, Huntington Richards, S. Theobald, Chas. A. Todd, O. D. Pomieroy and Lucien Howe.

French medical journals state that a flag will be displayed at the Medical Department of the University of Paris whenever a confinement is in progress in the Obstetrical Ward. The color of the flag will indicate the kind of confinement: a blue flag indicating that the confinement is a simple one, a yellow flag that the labor is difficult, and a green flag that an operation is necessary.

An elderly married couple, who had long lived childless, journeyed to Germany, where, to their great surprise, the wife became a mother.

This item will doubtless have the effect of diverting the stream of travel from Germany to other lands less famed for germs.

At the annual election of the directors of the Northeastern Dispensary, corner Monument and Gay streets, the following officers were elected for the ensuing year; Dr. Edward C. Baldwin, President; Dr. James P. Frames, Treasurer; Dr. George A. Hartman, Secretary; Drs. Samuel S. Powell, Richard Sappington, John H. Frames, Charles W. Hatter and James Billingslea, Executive Committee.

Dr. Skilakowsky, a famous physician in Russia, has received what is said to be the largest fee ever paid to a doctor in that country. A millionaire residing in Odessa summoned him specially to come there to perform some surgical operation. He performed the operation, and was in Odessa but five hours, receiving 11,000 rubles, or over \$8,000, as a fee for his trouble.

The new Croton aqueduct, which is now nearly ready for use, is 30.75 miles long, all of which is in tunnel, except for a trifle of over one mile. The water comes to the surface in four places, at which it can be emptied through gates into several streams. It starts from the Croton Lake in Westchester county, 350 feet above the dam, and the water flows down a uniform inclination of 7 1-10 feet to the

mile. The tunnel is a trifle over 13½ feet high and over 13 feet wide, and has an estimated capacity of 318,000,000 gallons a day.

The *Medical Record* says: There is a gynaecology, or science of woman, and now we learn that there is an "andrology"—which means, we presume, the science of man, and more particularly of man's diseases. "Andrology" has no lexicographical existence, or, at least, it is not to be found even in Foster's comprehensive work; but the word has been adopted as a part of the title of the "American Andrological and Syphilographical Association," so that now the profession may expect to have the "andrologist" as well as the gynaecologist.

The Faculty of the University of Maryland, not yet having elected a Professor of Anatomy, have decided to divide the work of that branch for the coming session between Professors Michael and Miles. Dr. J. Holmes Smith has been appointed Demonstrator of Anatomy. Professor I. E. Atkinson has been appointed Dean of the Faculty. The work of repairing and reglazing the hospital is rapidly approaching completion, and the new large addition is in course of construction. The private rooms have been remodeled refitted, provided with parquet floors and furnished with electric bells with cord attachment, so that the patient can ring from any part of the room.

Senator Hoar recently presented to the President a petition from the citizens of Boston asking that Dr. Billings in charge of the collection of vital statistics in the Census Office, be appointed Surgeon General of the Army, on the retirement in August, of Surgeon General Moore. There is a decided protest against this action by a number of others who are in the line of promotion in this office. Dr. Billings is ranked by thirty senior surgeons, all of whom will be passed over by this act. They resent

outside interference in these matters, and will vigorously resist in every way possible this innovation.

The *Western Druggist* says: The gullibility of our English cousins is a perpetual source of wonder to Americans, just as the propensity of the latter to practical joking is a perpetual snare and delusion to the average Englishman. Where on earth but in England could so manifest a lie as the following (which we copy from the *Monthly Magazine of Pharmacy*) receive credence? "The turpentine crop is likely to suffer in the United States for the want of axes. The great axe factories were destroyed last year by the floods, so that the turpentine farmers of the Southern States cannot get axes enough to supply the workmen." One single factory in Hartford Conn., or Providence, R. I., turns out enough axes every week to put a new one into the hands of every turpentine "boxer" in the United States.

A prize of 1,500 pesetas (\$300) is offered by the Royal Academy of Medicine and Surgery at Barcelona, under the will of the late Dr. Francisco Gari, of Boix, for the best essay on the following subject: "Antipyretic Medication in Acute Febrile Process: How Far is it Useful and Necessary to Combat Hyperpyrexia, and what are the Best Means of Doing So?" A second prize of 750 pesetas (\$150) will be given to the essay which comes next in merit to that to which the first is awarded. The title of Corresponding Member of the Society will be conferred on the winners of both prizes. The essays (which may be written in Spanish, French, or Italian) must be sent in to the secretary of the Academy (Baños Nuevos, num. 9, Barcelona) before noon of June 30th, 1891.

During twenty years 3,503 prostitutes were registered at Brussels. Of these, when asked their reason for living in this way, 1,523 attributed it to poverty, 1,118 to sexual appetite, 420 attributed their fall to bad company, 316 tired of hard

work and little pay, 101 abandoned by lovers, 10 quarreled with parents, 7 left by husbands, 4 quarreled with guardians, 3 had family quarrels, 2 were compelled to prostitute themselves by their husbands, and 1 by her parents. Nearly all said they would be only too glad to work if work could be secured. One of the greatest difficulties was that the markets were flooded with the products of convents, which undersold the work of women who had to support themselves. The strict regulation of prostitution exercised a wholesome effect in deterring women from entering this life. Poverty in Belgium renders prostitution a hard necessity; the alternative being starvation. .

The municipal committee appointed to determine the part to be played by the city of Berlin on the occasion of the approaching International Medical Congress has completed its programme. Every member of the Congress will be at liberty to visit the municipal institutions at any time. For those institutions, however, which are at some distance from the city, or for the inspection of which special preparations are necessary, certain days have been appointed. The programme is as follows: Monday, August 4th, inspection of the disinfectoin establishments and the slaughter-house; Tuesday, inspection of the water works at Tegel Lake, and a banquet in the Town Hall in the evening; Thursday, inspection of the irrigation fields in the south of the city; Friday; inspection of the irrigation fields in the north; Saturday, a visit to the lunatic asyecum at Dalldorf, followed by a *réte* at the New Palace, the Emperor's residence near Potsdam. In the medical exhibition in the Exhibition Park the city will exhibit the newest mechanical improvements in the Berlin hospitals, models, drawings of municipal buildings, and hygienic apparatus. A description of the hygienic and therapeutic institutions of the city, with illustrations, edited by the scientific assistant of the municipality, Dr. Buchholtz, under the superintendence of Professor Virchow, will be distributed among the members of the Congress.

MARYLAND MEDICAL JOURNAL.

VOL. XXIII. No. 13.

BALTIMORE, JULY 26, 1890.

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MEDICAL REPORT OF THE FIRST THREE YEARS OF THE FREE LYING-IN HOSPITAL OF THE UNIVERSITY OF MARYLAND.

BY L. E. NEALE, M. D., OF BALTIMORE.

This report is prompted by the obvious professional and lay reasons that render it desirable to make known the work done in our hospitals and medical charities, particularly those devoted to obstetrical practice.

I am also actuated by the usual custom of a retiring officer to submit an account of his services.

I shall premise the report by a brief retrospect that is not devoid of practical interest. Prior to the opening of the Free Lying-In Hospital in the spring of 1887, the University of Maryland, then

eighty years old, had few, or possibly worse than no facilities for teaching clinical obstetrics. The few cases treated in the general Infirmary under extremely unfavorable conditions, and the few more in the unorganized out-patient department were wholly inadequate in every respect for the requirements of modern clinical teaching.

Since the opening of the hospital and the better organization of the out-patient department, over both of which clinics I had practical charge as Chief of Clinic, more than three hundred patients have been treated in the hospital and a like number in the out clinic at their homes, making a total of some six hundred obstetrical cases offered for clinical teaching during the past three years.

As the returns made by the students on the charts for the out-clinic were very often imperfect or entirely wanting, I shall omit all consideration of these cases in this report which will be confined to the cases treated in the hospital where a more thorough record is maintained.

The hospital building is an old private dwelling house (622 West Lombard Street,) and consequently ranks far below the modern ideal obstetrical hospital, yet I think it can show a creditable record for the first three years, which is not entirely devoid of important practical suggestions.

Especially with respect to that dreadful disease, puerperal fever, which has been declared to be second only to Asiatic cholera in fatality, and which for the past five years has claimed for its victims one-twentieth of all women dying in New York City during the child-bearing period, with respect to this disease, the records of the obstetrical department of the University of Maryland during the past five years are by no means uninteresting.

During the early part of my service in this department as Chief of Clinic, and before the establishment of the Free Lying-In Hospital, obstetrical cases were confined in the general Infirmary and were subjected not only to its attendant dangers (which, under the then prevailing conditions, were very great), but were treated, as I then learned, according to a long observed custom, with the crudest, or what practically amounted to worse than no antiseptic precautions whatever.

I refer particularly to the then common practice of an untrained and unclean nurse (frequently one of the old female colored patients) administering vaginal injections with a foul syringe to almost every woman shortly after her confinement, and often more or less persistently during the puerperium. This generally constituted the only attempt at antiseptic midwifery. Few escaped puerperal fever more or less severe, yet under the prompt and efficient treatment of the house staff, few died.

In illustration; from March 1884 to March 1885, during a considerable part of which time this practice existed without my knowledge, out of 16 women delivered in the Infirmary 10 had puerperal fever, but none died. During the

following year, when, failing to have these injections administered properly, or only when specially indicated, they were finally stopped altogether; other unfavorable conditions, however, still prevailing, there were 13 confinements with only one case of fever, and that of a very mild type (sapræmia). The year after this afforded only one case of fever out of 20 confinements, but this one died from infection through a perineal laceration which became gangrenous.

Since the opening of the Free Lying-In Hospital in May 1887 to the date of these notes, May 1890, (exclusive), there were 308 confinements, and although many were extremely unfavorable emergency cases, and nearly all were examined by several (2 to 3) medical students (who, under the best regulations are doubtless a source of danger), the record shows only two cases of septicæmia and four cases of sapræmia with not a single death from puerperal fever in the hospital. Regardless of whatever doubts may arise relative to the correctness of a differential diagnosis between sapræmia (?) and septicæmia, this showing, I think, is at least creditable, and if this be so, it must be important to know how these results were obtained.

The building, as already mentioned, is an old private dwelling house with sanitary arrangements tolerably fair, but far from perfect, and I am of the opinion that in this respect there is still much to be desired, although several important improvements were made even after opening the hospital.

The closets and plumbing were greatly improved; the walls, ceilings, etc., were scraped and heavily white-washed, the floors, woodwork, windows etc. were thoroughly scrubbed and washed with antiseptic solution; all drapery hangings, furniture etc., removed and the building equipped with new, clean and simple (for the most part metallic) furniture. Chairs, bedsteads, washstands, etc., were all of metal, well painted and easily cleaned; spring mattresses were used, and the labor-bed was specially con-

structed for the purpose. In a word, the hospital was placed in as cleanly and antiseptic condition as was practicable under the circumstances.

This charity has 24 free beds, five wards, viz: three white and two colored, one confinement and one isolating room. As far as practicable the wards are used in rotation, and any case of fever is transferred at once to the isolating room.

The medical regulations are essentially as follows: With the exception of emergency cases, women are admitted only during the last few, usually two weeks of their expected confinement. On application or admission, the conditions found during this the primary examination, are recorded and compared with those found during the secondary examination at labor. On admission, patients are given a thorough bath, clean clothing and the regulation hospital gown. The general health and cleanliness of the women are constantly cared for during their stay in the hospital, the urine repeatedly examined, the bowels kept well open, and special treatment administered as indicated. The waiting-women under supervision of the house staff, assist in the house work until the date of labor.

At the commencement of labor, if time permits, a general bath is given, but in any case an antiseptic vaginal douche is administered, formerly consisting of a 1-2000 bichloride of mercury solution, but latterly of a two per cent. emulsion of creoline, and the external genitalia are scrubbed and washed in a bichloride solution.

The bladder is emptied and lower bowel washed out with a copious enema.

The woman is clad in a clean chemise and placed in the freshly and antiseptically prepared confinement bed.

Two or three students under supervision of the resident or visiting physicians attend each labor case, and they must comply with the usual antiseptic requirements relating to dissecting, attendance on contagious or infectious diseases, personal cleanliness, the wearing of clean linen dusters, etc.

Every examiner must previously clean

his finger-nails, and scrub his hands and fore-arms using stiff-brush, soap and hot water, and then immerse and rub his hands in an antiseptic solution of corrosive-sublimate or creolin.

No lubricant is employed for the examining finger, but it is taken fresh and wet from the antiseptic (2 p. c. emulsion of creoline) flexed so as to avoid contact with the bed clothing, and carried at once to the patient's genitalia.

Sometimes the antiseptic vaginal douche is repeated every 2 to 3 hours if the labor is unusually prolonged or there is special cause for infection. The late rupture of the membranes according to the plan suggested by Dr. Byford has been tried and abandoned; the membranes are now ruptured, other things being equal, when the os is dilated.

The uterus is followed down as the child is expelled and the placenta expressed according to the method of Credé.

As the placenta escapes it is caught in the hand and is not rotated, but is generally lifted straight out from the vulva. The membranes are not twisted in a rope, but are allowed to trail out straight, assisted if necessary by gentle traction on the placenta with one hand and pressure on the fundus with the other. If the membranes be caught in the cervix all pressure and traction is stopped for a while with a view of permitting the cervix to relax and then traction is made at discretion.

The rules for the internal removal or separation of placenta or membranes by hand or curette are those of the standard modern authorities; but I can recall only two cases where the placenta was removed manually and as that was done in my absence, I can not speak for its necessity from personal observation.

We do not ligate the cord as soon as the child has breathed or cried, but unless there is special reason to the contrary we wait until the pulsations have nearly or entirely ceased.

Our usual mode of resuscitating a child is by inversion or simply holding it up by the feet. The time-honored hot water

bath often proved exceedingly useful, and when artificial respiration became necessary the method of Schultz was employed.

Perineal lacerations are repaired at once with silver wire suture, neither silk, catgut nor silk worm gut seeming to give as good results.

An antiseptic post-partum vaginal injection is usually given just after labor, but I am still doubtful about its necessity if used as a purely prophylactic measure in perfectly natural cases, and I believe it should be discontinued as a routine practice and restricted to cases presenting some special indication. This is the opinion of some of the best authorities.

The intra-uterine injection is rarely used as a prophylactic measure just after labor, unless the hand or instrument has been introduced *in utero* or there is some other special reason to fear infection. But either in cases of abortion, premature or full-term labor, whenever the hand or instrument has been in the uterine cavity, either before, during, or after delivery, whenever there has been the slightest suspicion of decomposition of organic matter in the uterine cavity, from any cause whatever, e. g. blighted ovum, macerated foetus, long retained clots, pent up discharges, especially of a foul or purulent character, there is no hesitation about the administration of a thorough intra-uterine antiseptic injection to be repeated or not as indicated.

Regarding the use of the douche as a therapeutic measure in the treatment of puerperal diseases, we try to follow the advice of Lusk, viz. "look the patient over carefully before using the douche, and be governed more by her general condition than any one symptom." Indeed, I am inclined to place more reliance upon a rapid pulse (120) in the early diagnosis of infection than any other one sign taken separately.

I agree fully with Garrigues, that "the distinction between the various forms of septic infection is not practical at the bed-side," and with Miltenberger, that "it is unquestionably a disease of bacterial origin and that in all cases we must

acknowledge in its history only exosepsis or hetero-infection and that its cause is always heterogenetic." Therefore, I have dwelt somewhat at length upon the douche because whether we have poisoning from bacteria or ptomaine, whether we have septicæmia or sapræmia, I believe it is practically better to regard antiseptic precautions and the use of the douche as indicated alike in all. Indeed, in view of the fact that some of the worst and most fatal forms of poisoning may escape detection until the patient is practically doomed, I would rather err on the safer side and at once cleanse and disinfect the genital canal whenever and wherever there is the slightest suspicion of septic infection.

We should always bear in mind, however, that these antiseptic injections are by no means a harmless remedy, but may be potent alike for evil as well as for good; and I would here raise my voice with those who caution against and decry the needlessly repeated or long continued administration of the douche in obstetric practice. "Intra-uterine injections should not be given oftener than once or twice in twenty-four hours, vaginal every three hours."

This is particularly important in connection with the use of bichloride of mercury, for besides its other injurious effects Garrigues has collected 22 cases of fatal poisoning from this drug in obstetric practice. He believes that its use should be restricted to disinfection of the outer surface of the patient, hands of doctors and nurses, and material brought in contact with the patient, but he prefers a 2 per cent. emulsion of creoline for injections and otherpurposes. Creoline is an excellent antiseptic second only to corrosive sublimate; it is but little poisonous; it is a powerful haemostatic; it will not corrode instruments; and it makes all surfaces slippery; properties that particularly recommend it in obstetric practice despite the one objection to the opacity of its emulsion.

We use Garrigues' glass douch-tube connected by rubber tubing with a glass

reservoir mounted in an iron frame on rollers, the reservoir being usually raised some two or three feet above the patient who lies over a Searby's bed-pan.

We have never found it necessary to resort to any artificial means of uterine drainage.

Before leaving the subject of antiseptic injections in obstetric practice, I wish to state that what has here been said applies to hospital patients; for in private practice I use no antiseptic injections either ante-, inter-, or post-partum as a routine prophylactic treatment, but resort to them only when there is some special indication or reason as has been previously indicated.

Lusk has certainly given some very cogent reasons for the use of Garrigue's antiseptic vulva pad, (see *Medical News* May 31, 1890, p. 583) and we tried it faithfully in some hundred or more hospital cases; but as these cases did no better, if as well as another hundred treated without it, we discarded it as having proved in our experience unnecessary, considerably inconvenient and somewhat expensive.

No sponges are used in this hospital, antiseptic absorbent cotton being its substitute.

The following medical report has been compiled from an extract taken from the record book of the hospital by the two resident physicians in charge May 1st, 1890, Drs. Crouch and Ebaugh, and includes all cases treated in the hospital for the three years prior to that date.

MEDICAL REPORT OF THE FREE LYING-IN
HOSPITAL OF THE UNIVERSITY OF
MARYLAND FROM MAY 1, 1887,
TO MAY 1, 1890.

Women delivered	308
" died (1, shock after Cæsarean section; 1, urinary suppression)	2

CHILDREN:

Born, (5 cases of twins)	313
Died,	37

16 were premature, between 5 and 8 months.

10 bear no record of period of development.

11 were recorded at full term.

13 of those not known to be premature were still-born.

4 of these have no period of development stated.

3 still-births occurred in delivery by internal podalic version and extraction; 1 of these having a prolapse of the cord.

1 occurred in delivery by the high forceps operation.

1 in delivery by manual extraction in frank breech presentation.

In 8 cases of still-birth at term (?) no cause of death is stated.

7 of the 13 fullterm cases presented R.O.P.

5 " " " " " L. O. A.

1 " " " " " R. S. P.

8 died from 3 hours to 5 days after delivery; causes of death: malnutrition, maternal neglect, accidental killing.

1 acknowledged infanticide.

1 from haemorrhage from funis.

Of these 8 children, 6 bear no record of period of development, and only 2 are stated to have reached full term.

In connection with this serious mortality among the children (13 still-births out of 297 births presumably at term) it is but justice to state that many of the mothers were emergency cases who had been subjected to hardships, if not positive injury (self-inflicted or otherwise) before admission, and in several other cases the women purposely concealed their pains in order to escape examination by the students, and the nurse was only summoned after the delivery, at times only to find a dead child in bed by its mother.

It must also be remembered that a large majority of these births are illegitimate, and we have often suspected from circumstantial and other non-positive evidence the *facilis descensus* from illegitimacy to infanticide.

In regard to the two maternal deaths, one case (that of Cæsarean section) I do not hesitate to say in my opinion, was killed by fatal conservatism, for she was

in labor 14 hours before the section was undertaken, during the latter 6 hours of which time she had exhibited a well-marked Bandl's retraction ring besides having sustained considerable local traumatism incident to a high (Tarnier) forceps operation of one hour and five minutes duration. She never rallied from the operation and died from shock, 44 hours after the Cæsarean section. The child was saved.

The other case of maternal death occurred in a woman who was brought into the hospital after an eclamptic seizure in profound coma, and with complete suppression of urine from which she died shortly after admission and after delivery of a dead fetus. This was the only case of venesection.

SUMMARY CONTINUED:

Race	White	191
	Colored	117
Para	Primiparæ	205
	Multiparæ	103
Social Condition	Single	227
	Married (?)	69
	Widows	12
Age	Oldest (White)	45
	Youngest (Col.)	13
	Average	22
Children	Male	150
	Female	163
	Twins	5
 PRESENTATIONS.		
Vertex	L. O. A.	191
	R. O. P.	66
	R. O. A.	16
	L. O. P.	7
	L. O. T.	6
	R. O. T.	1
Breech	R. S. P.	2
	L. S. A.	3
	R. S. A.	1
Trunk	L. C. D. A.	2
	L. C. D. P.	1
Face	L. M. A.	1
	R. M. P.	1
Not Stated		15

These fifteen cases in which the diagnosis was not made, comprise street-births, precipitate and premature labors.

A difference between the diagnosis made at the primary examination on application or admission of patient, and the diagnosis made or verified at labor occurred in:

4 cases in the presentation,
23 " " " position,
14 " " " variety.

In this connection it is well to note that all of these (41) cases do not show errors in diagnosis, for in several instances the child was positively shown to have made a complete spontaneous version, not only from one position or variety to another (which is not at all uncommon at any period of pregnancy) but from one presentation to another. Indeed, I recall one instance where the spontaneous version from breech to vertex, back to breech, and again (3rd.) to vertex occurred during the last few weeks of gestation without any special treatment or effect upon child or mother.

I regard this subject as not only interesting but also of considerable practical importance, especially as bearing upon external version in connection with the examination (at least external abdominal by palpitation) of pregnant women during the latter (6) weeks of gestation and before labor, I have elsewhere reported some personal experience in this matter, and am sure in this country it is a "custom more honored in the breach than the observance."

There were 254 natural deliveries and 54 artificial deliveries out of the 308 cases, as follows:

ARTIFICIAL DELIVERIES.		
Low Forceps	21	
High "	12	
Int'l podalic version and extract'n	11	
Ext'l cephalic "	1	
Combined (int'l and ext'l) version	1	
Manual removal of placenta	2	
Manual extraction, (for breech)	4	
Craniotomy	1	
Cæsarean section	1	
Total	54	

Twelve of the thirty-three forceps cases sustained perineal lacerations (four from high forceps and eight from low forceps operation) and one child was still born (R. O. P.); while but one of the eleven internal podalic version and extraction cases sustained perineal laceration, with three children delivered by this operation still-born, one of the three however, being caused by prolapse and compression of the cord. The teaching of this school has been in favor of internal podalic version when easily practicable, *versus* the high forceps operations.

In the above cases of high forceps operation, the Tarnier axis-traction instrument was used, and it may be possible, as these statistics would seem to indicate, that this factor may have considerable weight in settling this much discussed and exceedingly important question in practical obstetrics.

DISEASES AND ABNORMAL CONDITIONS IN MOTHER AND CHILD.

Albuminuria	19
Eclampsia (3 post-partum, 2 ante-partum)	5
Contracted pelvis (C. V. 2 $\frac{3}{4}$ inches)	2
Hæmorrhage from the cord	1
Hydramnios	3
Hydrocele (in still-born child)	1
Hydrocephalus " "	1
Inflamed breasts (5 suppurated, 4 incised)	7
Malaria	2
Occiput posterior (remained and delivered post.)	4
Ophthalmia neonatorum (7 eyes lost)	8
Placenta-battledoor	3
Perineal lacerations (partial)	47
" " (complete)	1
Pleurisy	2
Pleuro-pneumonia	1
Post-partum hæmorrhage (slight)	5
Sapraemia	4
Septicæmia (purulent)	2
Shock (after Cæsarean section)	1
Urinary suppression	2

Of the 48 lacerations of the perineum, only one included the sphinc-

ter ani, (this one making a complete union after primary perineorrhaphy with silk,) and the majority did not extend through the transversus perinei muscle; 40 occurred in primiparæ, 8 in multiparæ 28 with female children, 20 with male children; 12 in delivery by forceps, 1 in delivery by version and extraction, and 10 in occipito posterior-positions.

The support, or rather protection of the perineum is tried in nearly all cases, often however, by unskilled hands e. g., students; the woman lying on her side with the hips well over the edge of the bed, the method used being that adopted in most of the German clinics.

In forceps operations, whenever it is possible to manipulate (by rectal pressure, external and bi-manual manipulation) the head through the vulva without the instrument, the forceps is removed. We do not believe the forceps can ever substitute the skilled hands as a means for protecting the perineum from lacerations.

I shall close this report with a brief statement of the facts according to the best of my knowledge regarding the recent very serious outbreak of ophthalmia neonatorum, my data being supplied by Dr Irwin Ebbaugh, resident physician at the time.

The routine practice of instilling into every child's eyes shortly after birth the prophylactic nitrate of silver solution (grs. x to the $\frac{3}{4}$ i) had been recommended, but doubtless had been neglected, in the large majority of cases, yet, we never had any serious trouble with the children's eyes, certainly none were lost, and I can not recall nor do the records at hand show any evidence of purulent ophthalmia prior to this recent outbreak, except in two (2) isolated cases that resulted in complete recovery.

CASE I.—White, born December 2nd, 1889. Mother had gonorrhœa. Ophthalmia developed in both eyes about the fourth day. Treatment, nitrate of silver solution grs. v to the $\frac{3}{4}$ j, once daily, and borax solution grs. x to the $\frac{3}{4}$ j every half hour, instilled into the eyes. Recovery.

CASE II.—White, born December 25th 1889. Ophthalmia developed in both eyes on third or fourth day. No cause stated. Treatment as in case I. Recovery.

No more cases of ophthalmia occurred in the hospital until the recent outbreak began *in another part of the building*, the colored ward, with—

CASE III.—Colored, born March 11th, 1890. Mother had gonorrhœa of virulent type and history of syphilis. Ophthalmia developed in both eyes on fourth day. Treatment as above; result: one eye lost and the other not well when the patient left the hospital. Ultimate result not known.

CASE IV.—Colored, born March 19th, 1890. Child died on third day, cause not stated, but one eye had already taken on a bad form of inflammation which was supposed to be purulent ophthalmia not fully developed. No cause of infection from mother.

CASE V.—Colored, born April 11th, 1890. Ophthalmia developed on fourth day in both eyes. Treatment, nitrate of silver grs. v to the $\frac{3}{i}$, once daily and a saturated solution of borax every half-hour, instilled into the eyes. The eyes improved for three days, then suddenly became worse and sight was lost in both eyes in twenty four hours. No cause of infection from mother. This child was delivered by internal version and extraction. No silver solution was instilled into the eyes at time of birth. I attended the delivery but did not visit the hospital after this date, and consequently did not see the following cases.

CASE VI.—Colored, born April 19th, 1890. Ophthalmia developed in both eyes on second day. Treatment as in Case V, the nurse attending to the eyes during the day and two students during the night. Sight lost in both eyes in 48 hours. No cause of infection from mother.

CASE VII.—Colored, born April 26th, 1890. As soon as child was born, nitrate of silver solution grs. v to the $\frac{3}{i}$ was instilled into its eyes. Ophthalmia devel-

oped on second day in both eyes, and notwithstanding the silver solution was increased to grs. x to the $\frac{3}{i}$ and used twice daily and the saturated solution of borax every half hour day and night, the sight was lost in both eyes in 24 hours. No cause of infection from mother.

CASE VIII.—Colored, born May 4th, 1890. As soon as child was born its head neck and face were washed in a 1-4000 bichloride of mercury solution, and a 2 per cent. solution of nitrate of silver solution was instilled into its eye. Within 4½ hours ophthalmia developed, both eyes filling with pus. The 2 per cent. silver solution was again instilled and the saturated solution of borax used every half hour. The pus disappeared, the cornea remaining clouded for a while, but were reported by Dr. Funck (Prof. Chisolm's Chief of Clinic), to have ultimately cleared up entirely, sight being perfectly restored.

Thus in this outbreak of ophthalmia, there were six cases resulting in the loss of sight in seven eyes, three children being totally blind and one blind in one eye.

I am informed that in several specimens of the discharge (pus?), from the eyes of this last case, examined by Dr. Randolph, of the Johns Hopkins Hospital staff, *after the eyes began to clear*, no gonococci were found, but as these cases were confined to the colored ward, as they occurred in rapid succession, and in several instances as they did not receive the instillation of the prophylactic silver solution (the treatment generally adopted in most of the German clinics), it seems hardly fair to attribute the result to these instillations as has been suggested.

319 West Monument Street.

MENTHOL AS A REMEDY IN VOMITING.

Recent reports in the *Therap. Monat. shefte* speak very highly of the efficacy of menthol as a remedy for vomiting in infants. The following preparation was used:

Menthol	gr. 15
Alcohol	fl. $\frac{3}{i}$
Syrup	fl. $\frac{3}{4}$

and the dose given was one teaspoonful every hour, or less frequently.—*American Druggist.*

STERNUTATION, AND AN
OBSTINATE CASE CURED BY
MEANS OF THE GALVANO-
CAUTERY AND THE
COLD-WIRE SNARE.

BY S. K. MERRICK, M. D.,

Professor of Diseases of the Nose, Throat and Chest,
Baltimore Medical College,

Sneezing being merely a symptom of disease, is only mentioned by authors in connection with pathological conditions, where it is prominently present. The act of sneezing, as you all know, is provoked by some irritant, direct or indirect (*i. e.*, reflex), to the Schneiderian membrane. Among the most common direct excitants of the act are certain drugs known as sternutatories, dust, mechanical irritants, *e. g.*, tickling with a feather or other analogous substance, certain odors, fumes from chemicals, and diseases of the membrane itself. Among the reflex, the most common excitants, the act of looking at the sun or any bright light to induce sneezing when one desires to—*i. e.*, has considerable inclination to do so, yet needs some help;—the rays of light falling on the retina provoke, through the optic nerve, the reflex stimulation necessary. It is hardly necessary to say the act of sneezing itself is a reflex act, being a spasmotic contraction of the diaphragm induced by an irritant, directly or indirectly applied to the Schneiderian membrane.

Of all the diseases in which sneezing is a symptom, none have this as a symptom so constantly as hay-fever, or asthma, and asthma, perennial. Taking cold (as it is termed), is accompanied or preceded in many persons by sneezing; polypi of the nose, especially the gelatinoid variety, give rise not infrequently to annoying sneezing.

But for the purposes of this paper a consideration of the pathological conditions covered by hay asthma and perennial asthma, or, what I regard as better names, vaso-motor rhinitis and vaso-motor

bronchitis, Bosworth will be quite sufficient as bearing more directly on the case which is to follow. As far back as 1872, Weber announced the theory that asthma was caused by a paresis of the vaso-motor nerves presiding over the bronchial mucous membrane. Voltolini followed and reported a case of asthma due to nasal polypi, as shown by the fact that asthma disappeared on the removal of the nasal growth. This observation was followed by a large number of similar reports by Hanisch, Porter, Daly, Todd, Spencer and others, as noted by Mackenzie in his book, "Diseases of the Throat and Nose," American edition, 1884, and gave rise to voluminous discussions by Schaffer, Frankel, Brogon, Hack and others, not only on asthma as a reflex disease due to nasal polypi, but as due also to other nasal disorders.

In a paper read before the American Climatological Association, May 28, 1885, Dr. Bosworth, of New York, first advanced the view that hay asthma and perennial asthma were virtually one and the same disease, the one being a vaso-motor rhinitis, the other being a vaso-motor bronchitis, the paroxysms being excited in each case by some peculiar atmospheric condition, as we know in hay fever is the presence of the pollen of flowering plants or some other vegetable emanation; whereas the atmospheric condition in perennial asthma, as we may designate those which occur throughout the whole year, is dependent upon some obscure element which we are not able to trace with that same degree of definiteness, we are enabled to trace it in hay fever. Hay fever is dependent upon three conditions:

1st, A neurotic habit, as shown by Beard.

2nd, The presence of pollen in the atmosphere, as shown by the unrivaled experiments of Blockley.

3rd, A disordered condition of the nasal passages, as shown by Daly.

Now, Bosworth claims that asthma is dependent on three conditions: 1st, a general neurotic habit or condition as demonstrated by Salter.

2nd, A diseased condition of the nasal mucous membrane (not the bronchial).

3rd, Some obscure condition of the atmosphere exciting the paroxysm. Without desiring to discuss whether or not these views be correct, I accept them as more satisfactorily explaining all the phenomena of these diseases than any yet adduced. I append a report of 80 cases of asthmatics treated by Dr. Bosworth in the last five years.

Of these 80 cases, 62 were accompanied or ushered in by sneezing. Of the total number, 34 were hay asthma and 46 perennial asthma; of the former, 29 had sneezing; of the latter, 33 had sneezing.

Intra-Nasal condition, Hay Asthma.

Hypertroph. rhinitis	9
" and deflect. sept.	12
Polypi "	5
"	4
Deflected septum.	3
Elongated uvula	1
	—
Perennial asthma.	34

Hypertroph. rhinitis	13
Nasal polypi	11
Hypertroph. and deflect. septum	11
Polypi "	6
Deflected septum	3
Adenoid and hypertrophic rhinitis	2
	—
	46

Dr. Bosworth says he has never known a case of hay asthma to occur in other than an obstructive lesion of the nose or upper air-passages—this was the case in every one of the eighty cases. It will be observed that there were 22 cases of the 80 when uncomplicated hypertrophic rhinitis was present. The treatment of these is what I shall quote as bearing directly on my case. The hypertrophic rhinitis in both diseases was treated by caustics. Cured of hay asthma, 7; improved, 6; unimproved, 1. Of perennial asthma, cured 8; improved, 5. Hypertrophic rhinitis (complicated), was present. 23—

making 45 cases in all where it was a factor. I have selected the above cases because we find so many pathological conditions present in the nose when sneezing may be a symptom, and when it actually was present 62 times; but in none of them does it appear that this annoying symptom was present in the exaggerated degree shown in my case.

Mr. G., age 47, paid his first visit to my office March 15, 1887. He came from a long-lived family on both sides; his mother, however, had pulmonary tuberculosis and died at 74 years of age with same. One sister died of same disease and one sister is now suffering from same disease and is under my care. There are four brothers, all of whom escaped the disease. The mother was doubtless a case of acquired phthisis, as I know three of her sisters now living, from 70 to 84 years old. Mr. G. went to East Indies in 1866, and located on the Delta of the Godavery river along the coast between Madras and Calcutta. He was not conscious of any trouble until '68 or '69, when he began to sneeze at table and had to wear a skull-cap to protect him from the effect of the punkero or large swinging fan which is used in that country universally. The use of the cap prevented the sneezing. Patient was bald, and it is possible a rhinitis was set up by the blast of air in a hot climate, when the head was constantly moist with perspiration at dinner hour. He began to experience catarrhal symptoms about this time. Patient remained in that country until 1874, suffering more or less from the fits of sneezing, and returned to Baltimore untreated, and did not receive any treatment until 1887. The paroxysms became more frequent and lasted longer, often sneezing ten minutes without an intermission of over a few seconds, and then often in 15 minutes to half an hour the same phenomena were repeated. Several times during my treatment when my office hours were nearly up, I have been compelled to leave him to sneeze 10 to 15 minutes, as he could not go on the street, the efforts were so violent

and continuous. The sense of smell was notably impaired. As I have before said, he came to my office March 15, 1887. An inspection of fauces was made and general hyperæmia of soft palate, with inflammation of pharynx and thickening, were present. Rhinoscope revealed same condition of naso-pharynx and considerable hypertrophy of inferior and middle turbinated bodies. Anterior inspection showed great hypertrophy in the olfactory tract, and not a little in the respiratory tract.

Mild alkaline, astringent, and antiseptic sprays by means of Sass' condenser were alternated faithfully, applied to nose and throat until April 14th, 1887, when I find first application of galvano-cautery to the middle turbinates. The sprays were now continued, and on May 11th, the galvano-cautery applied again to inferior turbinates. May 25th, 1887, to middle turbinates. June 9th, galvano-cautery again applied. Post. hyper. inferior R. turbinate to middle turbinates. July 15th, Post. hyper. snared, inferior left T.. snared. The sprays were continued until September, when patient stopped coming to office and did not return until December '87. Caught cold. Was relieved in a few days of sneezing. This case suffered for 17 years and he told me to-day that he rarely ever sneezes except about once or twice a month while dressing in the morning. The treatment was the same as used by Bosworth, and I believe the only successful one. This case is unique in being complicated with neither asthma nor polypi, and in being caused alone, apparently, by hypertrophic rhinitis, as the cure of the latter was followed by relief of all symptoms of the former.

420 West Biddle Street.

Dr. Walter Brashear, of Kentucky, was the first American surgeon to amputate the thigh at the hip-joint. This was done in 1806.

PERIODICITY IN MELANCHOLIA.

BY HENRY M. HURD, M. D.,

Professor of Psychiatry, Johns Hopkins University.

There is a form of melancholia developing in adult life generally in consequence of overtaxation which is characterized by a marked periodicity. After a long-continued period of great physical and mental depression, often accompanied by marked delusions of a painful character, generally of religious or personal unworthiness, the patient frequently passes suddenly into a state of considerable mental elation. Painful and distressing delusions are replaced by a sense of well-being and complacency; mental stasis with little spontaneous or natural mental action yields to an unnatural mental vivacity in which the patient becomes loquacious, full of schemes, elated and the absolute reverse of what he was when depressed. This period of elation is of comparatively short duration and is sooner or later replaced by another period of depression. In many instances the elation is so great that the patient loses self-control and precipitates an attack of depression by a rapid exhaustion of his feeble nerve force. The state seems the direct antithesis of pubescent insanity. The former comes on in adult life, the latter at puberty, the former has a long period of mental depression and a short period of elation, the latter has a long period of elation and a comparatively short one of mental depression. In both as in all other forms of mental disease characterized by a tendency to periodicity there is invariably to be found a hereditary tendency to insanity.

During the period of elation there is a manifest loss of a sense of the proper proportions of daily events. Trifling matters assume undue importance, engross the attention and monopolize the energies. A lack of sense of propriety, a disregard of consequences, a fertility in forming plans, with a fatal lack of ability

to execute them, and a fevered restlessness which constantly impels to purposeless activity, are characteristic of this condition. Before the period of elation comes to an end, the patient usually becomes wakeful at night, shows emotional instability, and has frequently, within a single twenty-four hours, sudden alternations of feeling, passing rapidly from the height of complacency to the depth of despair. There are generally no delusions during the period of elation. The change to a prolonged state of depression is generally abrupt. In the condition of depression there are apt to be loss of appetite, derangement of secretions, slowness of digestion, abdominal pains, muscular weakness and a sense of general malaise. Loss of memory, inhibition of mental action and marked mental torpor are also characteristic of this condition. The difficulty seems to be due to cerebral anaemia, with possibly, in certain cases a marked loss of tonicity of the cerebral vessels. The affection seems functional and differs from the depression which accompanies the atheromatous arteries of the victim of senile depression, or the arterio capillary fibrosis of the victim of Bright's disease or other deep-seated constitutional disease. In the latter cases, depression is a constant feature, and no alleviation of mental distress is apparent at any time during the course of the disease. That the former are cases of melancholia of a functional character is shown by the fact that there is actually no loss of mental vigor; in fact, during the period of elation there seems almost an increase of it.

The prognosis is invariably bad. Complete recovery is not to be expected.

There is generally a need of special treatment to maintain the comfort of the patient. During the period of depression, careful personal attention is all important to prevent him from falling into a state of complete mental apathy with accompanying loss of bodily health and vigor. At this time, routine work of a simple character under the super-

vision of a good nurse is all important. Personal care is also of equal importance during the period of elation, to prevent the inevitable exhaustion of strength which follows the attempt to carry into effect the multifarious schemes of the too busy brain. Women are much more apt to suffer from this form of melancholia than men. The grand climacteric seems to favor its development, especially when at this epoch of feminine life a person has been subjected to peculiar trials and hardships. The elation which accompanies this form is readily differentiated from the excitement of acute sub-acute, or periodic mania by its comparative mildness and its greater resemblance to healthy mental activity as well as by the absence of delusions.

Society Reports.

BALTIMORE MEDICAL ASSOCIATION.

STATED MEETING, HELD MAR. 12TH, 1890.

Dr. T. A. Ashby exhibited a

TUMOR

removed by him to-day, from a lady 35 years old, white.

The tumor has been growing for some time. It is a tubal tumor with ovary attached. It was distended with fluid, filling the pelvis. He attempted enucleation and the tumor broke, its contents were serum, blood-clots and seropus. He thinks it probably an extra-uterine foetation. She bore the operation well, but he does not know what the result will be as the woman was in a generally bad condition and has phthisis. She has just recovered from a localized pneumonia. She has been in bad health for over a year.

Dr. S. K. Merrick read a paper entitled

STERNUTATION, AND AN OBSTINATE CASE
CURED BY MEANS OF THE GALVANO-
CAUTERY AND THE COLD-WIRE
SNARE.

(See page 267.)

Dr. R. H. P. Ellis said we know more of reflex trouble from nasal disease now than we did several years ago. We have now many cases of reflex cough which were formerly thought due to lung or throat disease. He had a case, a man, apparently well in other respects, who could not ride in a street car where straw was, without sneezing violently, but was not affected in other cars. He found when he took quinine for several days preceding a ride, he did not sneeze, or if at all, not so much, the quinine lessening the reflex irritability. Very many cases of hypertrophic rhinitis, like Dr. Merrick's, get better after a man passes 45 or 50 years of age, as at or toward the decline of life, atrophy sets in and cases get well of themselves, without treatment.

Dr. Chas. S. Parker said he had a case similar to Dr. Merrick's, noticeable only in the peculiarity of the sneeze, which was a rapid succession of hish! hish! hishes!!! This was cured by the liberal use of quinine.

Dr. Jno. D. Blake thinks that probably Dr. Ellis' case was brought on by the odor of the straw. With some, certain odors, as of certain drugs, will bring on an asthmatic attack. With himself, dust will always do so.

Dr. J. I. Pennington asked Dr. Merrick if he had used chromic acid in any of his cases, and if so, with what effect.

Dr. Merrick said he had not because of the difficulty of applying it accurately. He has found that chromic acid in solution, runs down when applied and burns wherever it touches and he therefore prefers the galvano-cautery, which is always easily controlled.

In reply to Dr. Ellis, he said we do not see atrophic changes take place ordinarily at 50 years of age. If atrophy does take place, we still have a diseased mucous

membrane left; moreover, the air in larger volume rushes into the air passages, unmoistened, and serves as an irritant.

Dr. Pennington is glad to know that Dr. Merrick prefers the galvano-cautery as he has not gotten the good results from chromic acid that others claim.

Dr. Ellis referred to the experience of Dr. White of Philadelphia in the use of cocaine in hypertrophic conditions of the nasal mucous membrane. He himself finds that a 4 per cent. solution, in cases of acute rhinitis, often does good. In stronger solution it will so lessen the vitality of the membrane, that atrophy is induced prematurely. He does not think it of great value in nasal catarrh. He prefers a 4 per cent. or 5 per cent. solution of resorcin.

Dr. John D. Blake operated for stone, on a gentleman 48 years of age, who was deformed and a wreck physically. He was afraid the patient would not stand the operation. To his surprise, he got well rapidly, the wound healing by first intention and on the fourth day he was well.

He took two large stones from his bladder, whose combined weight was 4 ounces 11 grains. The man had been complaining nearly four years. The urine not only dribbled all the time while he was standing but when recumbent he could not retain it for any length of time. He occasionally passed blood, especially after urinating, when retraction and compression on the stone would irritate the bladder. The patient came to him for cystitis, not suspecting a stone, nor did he until he passed a sound.

The irregularity of the stones, was due to the fact that there were two, rubbing against each other. They are of the uric acid variety, as you see.

CASE 2.—A man, aged 42, who came to him a month ago. On making the incision he could not deliver the stone, on account of its size and he had to crush and take it out in fragments. It is of the triple phosphate variety and weighed 5 ounces, $3\frac{1}{2}$ drachms. This man had not complained long of the trouble. He

did not stand the operation as well as the other, but made a good recovery in the usual time.

Dr. W. F. A. Kemp said there was one thing remarkable in a case he had, in which, on post-mortem examination, five stones were found in the bladder. This was, that so long as there was no urine in the bladder and so long as the urine was alkaline, there was no pain and he could retain his urine.

Dr. Parker said he was called in to-day to see a boy, who had pain, for the first time, on urinating. He suspected stone, but on examination found an adherent prepuce and the bad symptoms.

Dr. John W. Chambers thinks that Dr. Blake's case not a very usual one. From the appearance of the stones, there was probably originally but one stone, which in some way ruptured.

Dr. Blake said the treatment, which he had somewhere seen recommended, that he always put such patients on, is a prescription composed of ac. benzoic., sod. bi-carb, and water. It gives so marked relief, the patient is inclined to believe himself well. It seems to produce a special soothing effect on the mucous membrane of the bladder. Calomel acts similarly but more slowly. He has had no good effect from sod. benzoat.

Dr. Thos. A. Ashby often uses the same prescription in cystitis of the female. Demulcent alkaline drinks will accomplish the same results.

Dr. Ellis asked Dr. Blake if he did not find alkalinity of the urine in cases of cystitis, due to ammoniacal decomposition of urine in the bladder.

Dr. Blake thinks the alkalis neutralizes the urine before it gets to the inflamed bladder, and that the irritation is due to the trickling down, on the inflamed bladder, of the acid urine.

Dr. Jos. T. Smith was called to see several children in an asylum, who complained, in school, of itching all over their bodies, etc. When he saw them the eruption was out and the children were dancing about the room in agony. The eruption was sparse in all. The

pruritus in each case was so great that on examination he could find scarcely a pimple whose head had not been scratched off. In only one case was there fever and in that it rose to $102\frac{1}{2}^{\circ}$ and then subsided entirely. The pruritus was easily relieved by greasing the body. There were 8 or 10 other children in the asylum but by isolation and disinfection, he prevented the spread of the disease. He has had several cases with no fever or catarrh but with only an eruption. After freely opening the bowels the eruption disappeared. These were probably cases of roseola.

Dr. R. H. P. Ellis said some epidemics are malignant; others, not. In this he has seen some things he has never met before. He has seen measles occur not only the second but even the third and fourth time. He has seen three cases where the child has had two distinct attacks inside of three weeks. He has seen several cases like Dr. Smith's, discrete in character, no catarrh, only slight fever and that disappearing on the eruption's coming out. He has seen light cases give rise to contagion of the most virulent character.

Dr. S. K. Merrick has had two cases under his care for throat trouble, both having eruption without fever. In several cases of measles he has had sore throat and tonsillitis to deal with.

Dr. W. F. A. Kemp attended a family in which three cases had measles. An old aunt in the house, 73 years old, who had hitherto escaped, had a well marked case.

HENRY B. GWYNN, M. D.,
Recording and Reporting Secretary,
724 North Gilmor Street.

A new Society, to be known as the Philadelphia Electro-Therapeutic Society, has been organized, with the following officers: President, Dr. G. Betton Massey; Vice-Presidents, Drs. J. Pearson Willits and Matthew J. Grier; Secretary, Dr. Wm. H. Wailing; Treasurer, Dr. J. J. Taylor. It starts with a membership of forty.

MARYLAND MEDICAL JOURNAL

Weekly Journal of Medicine and Surgery.

WILLIAM B. CANFIELD, A.M., M.D., Editor

Subscription \$3.00 per annum, payable in advance.

Contributions from practitioners in good standing invited, and advertisements from reliable houses solicited.

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BALTIMORE, JULY 26, 1890.

Editorial.**THE CAUSE OF ICTERUS NEONATORUM.**

It is well known to physicians that a form of jaundice frequently affects the new-born children which is not connected with disease of the liver nor any other harmful condition of the system. During the first and second weeks of life the skin of these apparently healthy infants becomes tinged with yellow. In ordinary cases this jaundice passes gradually away of itself, in feeble infants it may become more intense, the conjunctivæ becoming deeply stained and the stools being destitute of their normal color. Even then, recovery without injury to the general health may occur,

either spontaneously or with the aid of a grain of hydrarg. cum creta followed by a little castor oil. Various theories, all more or less unsatisfactory, are given by text-books in explanation of this phenomenon.

In an article on "Colorless Stools" in the *London Medico-Chirurgical Transactions* vol. 72, 1889, Dr. Walker puts forth a theory, based upon observation, which appears to elucidate the matter fully.

In the adult, bile is poured out very abundantly into the intestines, and while a portion of it is reabsorbed through the bowel walls, another portion is changed by the pancreatic juice with which it mixes, and is not absorbed, but is carried out with the feces, to which it gives the brownish color of health. When the pancreatic juice is not freely poured out into the intestines, an excessive amount of bile may be reabsorbed into the circulation and jaundice or staining of the urine may occur.

In the infant at birth the contents of the intestines are already mixed with bile which has been secreted during fetal life, and the color of the meconium is due to the presence in it of absorbable bile-pigments, since no pancreatic juice has as yet been added to convert them into the insoluble brown pigment of feces. When food has been taken by the infant and the pancreas has begun to secrete its fluid, part of the bile in the intestines is changed by contact with the pancreatic fluid and passes out with the feces, while the rest is, in a healthy infant, absorbed into the circulation and disposed of in the system. If the secretion of pancreatic juice is delayed or is deficient during the first weeks of life, while the liver is secreting bile in abundance, an excessive quantity of bile passes from the intestines

into the circulation and *icterus* results. With the increasing activity of the pancreas a normal condition is attained.

Icterus neonatorum is therefore the result of delayed or insufficient activity on the part of the pancreas, and not of disease of the liver, although a very free secretion of bile may be a factor in its causation.

This theory would render it necessary to suppose that up to birth and a little after it, the bowel walls were incapable of absorbing the bile salts and pigments of the meconium even when unchanged by the action of the pancreatic juice.

The relief afforded by mercurial aperients would be due probably to their stimulant influence upon the secretory apparatus of the pancreatic gland such influence being quite in accord with the well-known resemblance in function and structure of the pancreas to the salivary glands, which readily respond to the use of mercurials.

ACCIDENTAL SUFFOCATION AS A CAUSE OF SUDDEN DEATH.

When a physician or coroner is called in to see a case of sudden death, in many cases, especially when no foul play is suspected, the verdict is "death from cause or causes unknown." Occasionally an autopsy is demanded, but even then the cause may not be forthcoming.

Drs. H. M. Biggs, and W. T. Jenkins, (*N. Y. Medical Journal* July 12th, 1890) think that physicians do not give sufficient consideration to this subject, probably "because they are accustomed to consider that their responsibility has reached an end when death has occurred." The writers, knowing that the common cus-

tom is to attribute sudden death to some disease of the heart or blood-vessels, wish to emphasize in this paper the number of cases where death can be attributed to suffocation as a cause, and they conclude as follows:

1. Accidental suffocation is a common cause of sudden death, especially in children, and the cause of death usually escapes recognition.

2. Death produced by the lodgment of foreign bodies in the larynx or trachea occurs rapidly, and is sometimes almost instantaneous. The foreign body may be liquid as well as solid.

3. When death is instantaneous, it is probably the result of reflex inhibition of the heart's action.

4. In children the foreign body is usually some play-thing that has been placed in the mouth, while in adults it is almost invariably an alimentary bolus, frequently meat.

5. The accidental suffocation of infants in bed by the bed-clothing and by "overlying" is a very common occurrence among the lower classes.

6. Death often results from suffocation during epileptic convulsions and during profound alcoholic intoxication.

Reviews, Books and Pamphlets.

Transactions of the American Pediatric Society. Vol. I. Printed by J. B. Lippincott Co. Philadelphia, 1890.

The gradual tendency towards specialism in medicine and the increasing importance of the diseases of children, particularly in the warm months, has led to the foundation of this society. It is

the outcome of the Ninth International Medical Congress and its inception is due to the suggestion of Dr. W. D. Booker, its secretary.

The society met for organization in 1889, and has been in existence since that time. It very wisely, however, withheld its transactions from the public until they should have reached the value which this volume shows. Among the members from Baltimore are, besides Dr. Booker, the secretary, Drs. T. S Latimer, H. A. Lafleur, and Wm. Osler.

The articles, all of which have appeared in the *Archives of Pediatrics* for the past year, present a varied assortment of matter well worth reading.

Supra-Vaginal Hysterectomy. Hysteromyectomy with Suspension of the Stump in the Lower Angle of the Abdominal Incision. By HOWARD A. KELLY, M. D., Gynaecologist to the Johns Hopkins Hospital, Baltimore. Reprinted from the *Medical News*, June 28, 1890.

Dislocation of Cervical Vertebrae, without Fatal Results. By G. L. WALTON, M. D., Instructor in Diseases of the Nervous System, Harvard University, etc. Reprinted from the *Boston Medical and Surgical Journal*, May 8, 1890.

Injuries of the Bladder during Laparotomy. Including a Report of Sixty-Seven Cases. By A. REEVES JACKSON, A. M., M. D., Chicago. Reprinted from the *Journal of the A. M. A.*, February 22, 1890.

Conservatism in Nasal Surgery, By CHAS. M. SHIELDS, M. D., Richmond Va. Reprinted from *Practice*, April 1890.

Miscellany.

A DRESS REFORM LEAGUE.

The close relation between health and wholesome dress need hardly be insisted

on. It does not, indeed, find adequate expression in the clothing of the present day, but this is rather to be attributed to the helplessness engendered by custom or to an immovable conservatism than to any desire to dispute the truth of the proposition above stated. It is, therefore, most satisfactory to learn that a new league is in process of formation, which has for its object the reform of women's dress. The supporters of this association believe that it is possible to introduce radical changes into existing modes of clothing without sacrificing what is due either to health, comfort, or grace. They maintain very sensibly that the problem with which they are concerned "can only be solved on broad principles, allowing the maximum of variety" in styles of dress. Among these principles are the following:—1. Compression of the waist by a corset involves undue pressure, and especially in the case of growing girls ought to be discontinued. 2. The limbs, upper and lower, should be so clad as to allow them the freest possible movement. 3. Clothing should be so light and so supported on the body as to make the least possible demand on the strength of the wearer. In order to attain these ends, they observe, it should not be needful to carry out any marked alteration in the outer clothing, and a woman thus rationally attired will not exhibit any other peculiarity than the charm of more supple grace possessed by a figure draped with due regard for its natural outline. We observe that, in the scheme of work published on behalf of the league, no allusion is made to head or foot coverings. This is evidently an unintentional omission which further consideration will remedy.—*Lancet*.

HYDRAMNION IN TWIN PREGNANCY.

Dr. Kruse, of Greifswald, described in the *Deutsche med. Wochenschrift*, No. 5, 1890, a case where this interesting condition occurred in single-arm twin pregnancy. The patient was aged 41, and

had borne seven children. After a fall, the abdomen suddenly increased in size, and dyspnoea set in. When admitted into hospital, twin pregnancy at the sixth month, with hydramnion of one foetus, was diagnosed. An elastic catheter was introduced, in order to induce labor, but without effect. The membranes were ruptured, and the twins were then rapidly expelled. Seven quarts of liquor amnii came away. The twins and membranes were carefully examined. None of the conditions alleged by some authorities to be the cause of hydramnion in single-ovum twin pregnancy were present. One foetus was smaller than its brother, but there was no anaemia of the one with corresponding plethora of the other. The placental circulation was perfect throughout the placenta and cords. The bladder of the bigger foetus was greatly distended with urine, the ureters tortuous, and the renal pelvis dilated. This condition was attributed by Dr. Kruse to a mechanical impediment to the escape of urine. That impediment was, in his opinion, the pressure of the amniotic fluid; for there was no obstruction of any kind in the genito-urinary tract itself. The hydramnion was thus not caused by polyuria in the foetus. The smaller size of one foetus Dr. Kruse attributed to the fact that it received blood from a less extensive surface of placenta than in the case of its brother. In short, the cause of the hydramnion could not be determined.

—*British Medical Journal.*

SNUFF FOR COLDS.

The following is a convenient formula to be used in place of solution of cocaine:

B	Sodii bicarb.	grs. ij.
	Magnesiæ carb. (Levis)	" iij.
	Menthol	" i.
	Cocain. hydrochlor.	" iv.
	Sacch. lactis	3 iss.
M.	Sig.: Use as snuff.	

It is said that the most marked relief follows the use of this powder, and a few

applications will do much to abort the catarrhal attack. Its effects are immediate, highly agreeable to the patient, and continue for a number of hours.—*Chemist and Druggist.*

RED NOSE.

In twenty per cent. of the cases of red nose the redness is caused by acne rosacea. When rosacea is the cause, Unna gives one-half grain of ichthyol internally, and, at the same time, applies it externally in aqueous solution at night, or he prescribes the following sulphur-zinc paste as given in the *Chemist and Druggist*, May 31, 1890, to be applied at night:

R	Ung. zinci	20 parts
	Amyli oryzæ	5 "
	Sulphuris	2 "

Later on, Unna has the enlarged venous trunks punctured with Hebra's instrument two or three times per week; the little wounds are immediately covered with wet cotton. For very mild cases and for supplementary treatment repeated washing with ichthyol soap is recommended, warm water only to be used, as in all cases of rosacea.—*Medical and Surgical Reporter.*

RESORCIN IN EPITHELIOMA OF THE FACE.

Dr. Mario Luciani reports two cases of "cutaneous epithelioma" in which he claims to have effected a complete cure by the application of an ointment containing resorcin. In one case the patient, a healthy woman, aged 55, had had a small red nodule on the forehead for four years. It then began to grow larger and became ulcerated, the ulcer having hard borders and a foul base, and being very painful. As the disease was spreading and the patient would not hear of any thing in the nature of a surgical operation, Dr. Luciani directed that an ointment composed of thirty grammes of resorcin to one hundred grammes of vaseline should

be applied once a day to the ulcerated surface after previous cleansing with a 2 per cent. watery solution of borax. In a month the ulcer assumed a healthy appearance, its edges softened, and the burning and shooting pain formerly complained of ceased. After three months' further continuance of the treatment the ulcer completely healed. The second patient was a woman, aged 60, who for about a year had noticed a small lump on her upper lip near the corner of the mouth on the right side. Ulcerations took place, and the course of events was similar to that in the previous case. The same treatment was followed by an equally happy result. While Dr. Luciani is to be congratulated on his success, some doubt may, perhaps, in the absence of microscopic or other conclusive evidence, be expressed as to the true nature of the disease with which he had to deal.—*British Medical Journal*.

WHOOPING-COUGH TREATED WITH TERPINE HYDRATE.

Manasse (Therap. Monatshefte, 1890, 116) gives some account of the constitution of terpine hydrate and of the uses for which it has been recommended, and then reports his own experience with it in the treatment of whooping-cough, having tried it in 41 cases with excellent results. In children less than one year old it may be given in dose of 22 grains per day without any deleterious effects. A careful history of each case was kept, the number of paroxysms being noted daily. In the great majority of cases 22 to 45 grains daily were sufficient in the course of four to five days greatly to reduce the number, or, at any rate, the severity of the attacks; and to hasten the recovery from the attending bronchitis.

In endeavoring to explain the method of its action, he discards at once the former view, that pertussis is in any sense a neurosis of the pneumogastric or phrenic, accepting the theory that the disease is of mycotic origin. As terpine hydrate has been shown by Colpi to

possess quite powerful antiseptic properties, we might assume that the value of the drug depended upon its action upon the germs of pertussis. The authority is, however, of the opinion that little is ever to be gained by the attempt to cure any infectious disease by attacking the germs themselves, since these bodies are much less apt to be injured by drugs than are the tissues of the human organisms. In pertussis we have an inflammatory and catarrhal condition of the respiratory mucous membrane, which, in the severe cases, may increase to a grave condition, blocking the capillary bronchi with mucus and cellular masses, and producing alveolar collapse, lobular hyperæmia, degeneration of the terminal bronchioles, and death. Terpine hydrate does good by causing a contraction in the blood vessels, and thus producing an anæmia of the respiratory mucous membrane with diminution of its swelling and increase of the secretion.—*American Journal of the Medical Sciences*.

CARTER'S LITTLE LIVER PILLS.

Weight of twelve pills, about $7\frac{1}{2}$ grains, of which probably 2 to $2\frac{1}{2}$ grains is sugar-coating. They contain podophyllin and aloes, made into a pill and coated with sugar. On the above we deduce the following formula as closely resembling the original:

Podophyllin	1 $\frac{1}{2}$ grs.
Aloes, Socotrine	3 $\frac{1}{2}$ grs.
Mucilage of Acacia	q. s.

Mix, divide into twelve pills, and coat with sugar.—*The New Idea*.

NITRATE OF COCAINE IN THE URINARY PASSAGES.

Dr. Lavaux thinks the nitrate of cocaine should replace the hydrochlorate of the drug for genito-urinary employment, where nitrate of silver is to be used. In the *Journal de méd.* of March 23, 1890, he relates some experiences

with the nitrate in connection with somewhat strong nitrate of silver injections. The following formula is given as one recently employed in gonorrhœa without the production of pain.

R	Distilled water	50 grammes;
	Nitrate of cocaine	1 grammme;
	Nitrate of silver	1 "

The canal is to be washed out with a four per cent. boric solution before and after injection.

The nitrate of cocaine is readily prepared by pouring a solution of the hydrochlorate of cocaine into a solution of nitrate of silver. By double decomposition a precipitate of chloride of silver, wholly insoluble, falls down, and the nitrate of cocaine remains in solution.—

Journal of Cutaneous and Genito-Urinary Diseases.

THIOL IN SKIN DISEASES.

Prof. Schwimmer, of Buda Pesth, has used thiol, a substance very similar to ichthylol, but free from unpleasant odour, and made by heating gas oil with sulphur, in a large number of skin diseases with remarkable success. In herpes zoster, acne simplex, and rosacea, in moist eczema and in burns, he paints the affected part with a solution in distilled water, of the strength of 1 in 4, twice a day, not washing the application off for two or three days. In some longstanding cases the washing is still longer delayed. In some cases an ointment (1 to 3) was employed, and in some the dry powder itself.—*Lancet.*

THE LIVER IN DIABETES.

M. Frantz Glénard has recently been contributing to the *Lyon Médical* a series of papers on the condition of the liver in diabetes. His conclusions are founded upon the systematic examination of 324 diabetic patients (234 men, and 90 women) observed in private practice at Vichy; he found some manifest alteration in the liver in no less than 60 per cent. of his cases. Hypertrophy was the change most frequently observed; it was

present in 34.5 per cent. In 23 per cent. there was indolent induration of the liver. He believes that he has been able to trace a regular series of changes—hypertrophy being followed by shrinking, in some cases by atrophy, and in any case leaving a liability to fresh attacks. The most characteristic point about the hypertrophy appears to be that it is generally limited to the right lobe.—*British Medical Journal.*

Medical Items.

Thirty thousand arrests for drunkenness are annually made in New York City.

Dr. and Mrs. George H. Rohé have returned from their trip much improved in health.

The Philadelphia *Medical and Surgical Reporter* has investigated all possible reports of persons being buried alive, and has yet failed to find one authenticat d case.

The State Board of Health announces to physicians outside of Baltimore, that death from certain contagious and infectious diseases must be reported to that body under penalty of a fine.

Professor Jolly, of Strassburg, has been appointed to the chair of Mental and Nervous Diseases in the University of Berlin which has been vacant since the death of Professor Westphal.

The Bradshawe Lecture of the Royal College of Physicians, London, will be delivered on Monday, August 18th, by Dr. Saundby, on the "Morbid Anatomy of Diabetes Mellitus."

The physicians of New Orleans, who started a training-school for nurses, having failed, the ladies took it up, and have carried it through the first year with a fair prospect of success.

The State Board of Health has begun its inspection work by prosecuting a milk dealer for the sale of impure milk. The markets are also closely watched and food unfit for consumption is seized and destroyed.

The Mayor, Health Commissioner and Inspector of Buildings, of Baltimore, have selected a lot belonging to the city for the new morgue, at the corner of Lancaster and President streets. Health Commissioner Rohé will visit some of the larger cities to examine the morgues there.

The Italian Government has ordered that only medical men shall henceforth be entitled to practise dentistry and blood-letting—an order which will interfere with the practice of a large number of quacks, and which is therefore looked upon with satisfaction in medical circles.

The *Times and Register* says "we stand out, solitary and alone, as the one and only medical journal that said a good word for Billings' census circular. If this doesn't make us solid for the next \$30,000 investigating committee, then gratitude has ceased to inhabit the human heart."

The Alvarenga Prize, of the College of Physicians of Philadelphia, consisting of one year's income of the bequest of the late Señor Alvarenga, of Lisbon, has been awarded to Dr. R. W. Philip, of the Victoria Dispensary for Consumption and Diseases of the Chest, Edinburgh, for his Essay on Pulmonary Tuberculosis, which will be published by the College.

In his report upon the Convention for the revision of the U. S. Pharmacopœia of 1890, Dr. Benjamin graphically demonstrates the business capacity of the preceding committees. The work was given out to be published by a New York house, which realized profits of somewhere between \$20,000 and \$54,000, while

the distinguished but stupid men who did the work received nothing.

Dr. J. DeLeon, of Ingersoll, Texas, reports a case of birth of quadruplets who are all living and doing well. Pennsylvania also comes to the front with a similar case. When we get up a baby food, trade-marked and well under way, we intend to have several Tennessee women to give birth to quintuplets. It makes it so nice to sandwich a line of advertising into one of these cases of hyper-fecundity.

Rev. De Witt Talmage is credited with the following:—"Established physicians, encourage young doctors by telling how you yourself once took measles for scarlatina. Don't walk around with a profundity and overwhelmingness of manner as though you were one of the eternal decrees. And if you have nothing to say that is encouraging, compress your lips, put your hand on your mouth and keep still."

The pioneer school for male nurses in this country is in connection with the Bellevue Medical College in New York. The Superintendent of this training-school is a woman, Mrs. O. S. Willard, a graduate of the Bellevue School for Women Nurses. Six young women, graduates of the same establishment, give ward instruction to the men, there being, it is said, no male nurses to be found who are competent to this task.

In an action recently brought by a medical man in Belgium to recover 24 francs (\$4.80) the amount of his fees for eight visits paid to a patient, the *juge de paix* reduced the claim by one-third on the ground that "medicine is a philanthropic profession." if this be a sample of "justices' justice" in Belgium, it is to be hoped that those other philanthropists, the butcher and the baker, may have the same measure meted out to them when they invoke the aid of the law to recover their debts.

The Royal College of Physicians of Edinburgh is to be represented at the Tenth International Congress in Berlin by Dr. Grainger Stewart, physician to Her Majesty the Queen in Scotland, Professor of Practice of Physic and of Clinical Medicine in the University, President of the College; by Dr. Batty Tuke, Lecturer on Insanity in the Edinburgh Medical School, member of the General Medical Council; and by Dr. G. A. Gibson, Lecturer on the Practice of Medicine in the Edinburgh Medical School, secretary to the College.

A suit of damages has been instituted against a physician of Philadelphia for neglect of duty. The facts of the case are: During the prevalence of the epidemic of influenza, the physician was called to a woman suffering with the disease. He saw her once, but like hundreds of others was overrun with work, and when he called again found another doctor in attendance; consequently he withdrew. The woman died and the second doctor alleged that the disease had so far progressed, when he was called, as to render recovery hopeless.

The Mississippi Valley Medical Association will hold its 17th, annual meeting at Louisville Ky. October 8th, 9th, and 10th. 1890. The profession is invited to attend. Gentlemen wishing to read papers will please to send in the titles as soon as possible to the secretary, Dr. E. S. McKee, 57 West 7th St., Cincinnati. The American Rhinological Association will also hold its annual session at the same place the same week, viz. October 6th, 7th, 8th, 1890. Titles of papers should be in the hands of the secretary, Dr. R. S. Knodle, National Bank Building, Omaha Nebraska, at an early date.

The census of lunatics, blind persons, deaf-mutes, and cretins under private care in Austria, which was recently ordered by the Minister of the Interior, is now in active progress. Its object is to make it possible to exercise more

thorough supervision of all such cases, as many instances have been brought to the knowledge of the authorities in which helpless patients of one or other of the classes referred to have been removed from public establishments and placed in charge of persons who have not given them proper attention. The regulations as to the transfer of patients from public to private care have been made more stringent.

The statement made in the last issue of the JOURNAL, on what was considered good authority, that Dr. Wm. Lee had given up his city practice, is incorrect. It is a great pleasure to his many friends to announce that Dr. Lee will continue to practise in the city. While residing in Baltimore County, he has opened an office at No. 344 North Charles Street and has limited his practice to Deformities and Diseases of the Skin. At the Baltimore Medical College Dr. Lee, as Lecturer on Dermatology, will deliver a thorough course of lectures on diseases of the skin, and in addition to clinics, the microscope will be used when needed, and numerous plates of the different diseases will be shown.

Smokers may be pleased to learn that Dr. Gautreler, of Vichy, claims to have discovered a method of rendering tobacco harmless to the mouth, heart, and nerves, without detriment to its aroma. According to him, a piece of cotton wool steeped in a solution (5 to 10 per cent.) of pyrogallic acid inserted in the pipe or cigar holder will neutralize any possible ill effects of the nicotine. In this way not only may the generally admitted evils of smoking be prevented, but cirrhosis of the liver, which in Dr. Gautrelet's experience is sometimes caused by tobacco, and such lighter penalties of overindulgence as headache and furring of the tongue may be avoided. Citric acid, which was recommended by Vigier for the same purpose, has the serious disadvantage of spoiling the taste of the tobacco.

MARYLAND MEDICAL JOURNAL.

VOL. XXIII. No. 14.

BALTIMORE, AUG. 2, 1890.

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THE TREATMENT OF POISONING BY ILLUMINATING GAS WITH NITROGLYCEPIN.

BY WILLIAM C. KLOMAN, M. D.,
OF BALTIMORE.

Nearly one year has elapsed since I was called upon to treat a case of poisoning by illuminating gas, and the idea occurred to me to inject subcutaneously nitro-glycerin. This case was published in the *New York Medical Journal*, October 26th, 1889. The use of the remedy was suggested by the desperate condition of the patient, who had been exposed to the inhalation of gas during an entire night; a period of certainly not less than 7 hours. The door and window of the room were closed, and why she was not found dead can only be explained by the

fact that the stop-cock was only partially turned on and that some organisms offer a much greater resistance to the action of the poison than do others. In this case the coma was profound with complete anæsthesia. The open eyes could be touched without eliciting any movement. There was no pulse and the only evidence of remaining life was a shallow breathing at long intervals. Here was a case that in all human probability would have had a fatal termination under the former methods of treatment. At all events, even had recovery ensued, the convalescence would have been tedious and extended over a number of days, possibly a week.

I had for sometime been using nitro-glycerin in conditions of heart depression, chloroform narcosis, shock etc., and the thought was that under the circumstances in which I found the case, if any remedy would afford benefit, it would be nitro-glycerin. I at once dissolved one of Sharp and Dohme's unequalled tablets

and injected the solution into the cellular tissue of the arm. Within two minutes I could begin to feel the heart faintly beat and in five minutes there was pulsation at the wrist. In about fifteen minutes she manifested symptoms of nausea and vomited some undigested food from the previous evening, among which were pieces of raw tomato. She continued to rally steadily and in the course of a half hour, having become partially conscious, I ordered her

Ry Ether Sulph, $\frac{2}{3}$ ss.
Elix. Ammon. Valer. $\frac{2}{3}$ iss. M
Teaspoonful every 2 hours.

I then left to get my breakfast, &c. I returned about 10 o'clock A. M., and to my amazement she walked into the parlor. Her only complaint was of slight headache. From this time she again performed her usual duties and the only other medication needed was a slight purgative for constipation.

I have been tedious in again detailing part of this case because of its bordering on the marvellous. In consequence of its first publication I have seen accounts of four (4) other successful cases published. Two of the gentlemen publishing these cases, Dr. Hill, coroner of Baltimore City, and Dr. F. X. Dooley, of Washington, D. C., were kind enough to state that they used the remedy because of my publication. I have recently had another successful case, making 6 cases, without a single case of failure, so far as I know. This record ought to commend its adoption and use to the profession.

The opinion as to the mode of action of illuminating gas upon the organism is very much divided. One fact universally conceded is that the poisonous quality of the gas is due to the carbonic oxide contained. The amount of this varies materially according to the method of production. If made from coal, the gas contains about 7.5 per cent. carbonic oxide, when made from water, by the modern method, it contains from 24 to 30 per cent. The researches of Claude Bernard, Lothen Meyer and Hoppe-Seyler have also established the fact that carbo-

nic oxide displaces the oxygen from the blood; it decomposes the oxyhaemoglobin and forms a new crystallisable compound with the haemoglobin, which is incapable of absorbing oxygen and consequently of sustaining life. So far there is unanimity. But from this point writers differ materially as to how the gas produces the symptoms of poisoning. Boehm, in Ziemssen's Cyclop. of Med. Vol. 17, says: "Whilst one set considers that the symptoms of poisoning by carbonic oxide are perfectly explained by the above theory, and regards the whole symptoms as essentially a form of suffocation produced by want of oxygen (Claude Bernard, Hoppe Seyler, Pokrowsky, Friedberg), others insist most strongly on disturbances in the circulation (atony of the muscular coat of the blood-vessels), which must be considered as a result of poisoning by carbonic oxide, not dependent on its power of robbing the blood of oxygen. (Klebs). They consider that this poison acts like a narcotic on the organs of the central nervous system (Siebenhaar and Lehmann).

My own observations lead me to agree entirely with the former of the theories mentioned, that all the symptoms can be satisfactorily explained by the robbing of the blood of its oxygen. I should decidedly exclude any idea of an intrinsic narcotic action on the central nervous system. All the symptoms when carefully analysed can be explained by this theory, and the symptoms developed are such as one would, *a priori*, expect from such a cause. The marked depression of the circulatory system is readily accounted for by the absence of its customary stimulant, the blood charged with vitalising oxygen and by the absence of its proper innervating force sent from the central nervous system. In turn the depressed circulation acts upon the central nervous system in a two-fold manner, there is less blood circulating and what little does circulate is of a vitiated and depraved character, not capable of sustaining the vital functions.

Again, in endeavoring to explain the action of nitroglycerin in relieving these

cases, this theory is also sustained. All therapeutic writers, with whom I am acquainted, state that nitroglycerin paralyzes the inhibitory function of the par vagum on the heart. It does more, it paralyzes the inhibitory centre for the vaso-motor system, for, one of the most prominent effects produced by its exhibition, is a flushing of the face and a glow of warmth over the entire surface of the body. We have then a freer, fuller action of the heart and at the same time a dilatation of the capillaries and arterioles giving a much larger supply of blood. As the supply of blood, even if vitiated, increases, the respiratory centre is correspondingly stimulated and an increased supply of oxygen soon aids in replacing a portion of the lost oxyhaemoglobin.

But this, to my mind, does not altogether explain the action of the nitroglycerin. The recovery from an almost hopelessly moribund state in the course of a few hours, when we recollect that heretofore days have elapsed before patients convalesced to the same extent, cannot be explained by a simple stimulant action of the drug. It must, in some manner, decompose the new compound of carbonic oxide with the haemoglobin and render the latter again capable of absorbing oxygen and combining with it. This can only be tested and demonstrated in the laboratory. Can it be that the large volume of gases into which the nitroglycerin is decomposed and to which it owes its explosive force may furnish us with an explanation? Zuntz and others state that this new compound can be decomposed by passing other gases through the blood.

That the circulation in the blood of a large quantity of this deleterious new compound of carbonic oxide with the haemoglobin retards recovery, is apparently proved by the experience of a brother physician, who narrated to me a case which he treated a few years ago. The patient was robust and in a state of profound coma with depressed circulation for several days, and making no progress under ordinary treatment, when he sug-

gested bleeding in order to withdraw some of the vitiated blood. This was done and the patient improved from that time.

I will here state that there were no convulsive movements among the symptoms in either case which I saw.

As to the treatment of these cases it is exceedingly simple. The patient should of course be immediately removed into pure air and placed near an open window or door. All clothing restricting free respiratory movements should be removed. The head of the patient should be low, the body horizontal. As early as possible $\frac{1}{5}$ of a grain of nitroglycerin should be injected into the outer side of the arm. This is most satisfactorily done with the hypodermic tablets now furnished. I dissolve one of these tablets in the barrel of my syringe in 15 minims of water, making a concentrated solution. Where the tablets are not to be had, two drops of a one per cent. solution of nitroglycerin in alcohol will furnish the same amount and may be drawn into the syringe, and afterwards some water added. This one injection has sufficed to do the work in the cases I have had. Should the pulse not respond satisfactorily in one-half hour, I would feel no hesitation in repeating the injection. The remedy is generally well borne and has not produced any untoward symptoms in moderate doses. I am now treating a case of fatty degeneration of the heart, to whom I have given $\frac{1}{5}$ of a grain of nitroglycerin every four hours during the past three months with great benefit.

External stimulation by friction, rubefacient applications or even electricity I have not resorted to, for I found the nitroglycerin bringing on reaction as rapidly as possible without them; yet I do not see how they can do harm unless they cause the neglect of the hypodermic injection of nitroglycerin.

Should sequelæ occur, they must be treated on general principles. I have never met with any.

In conclusion I will state that I believe, in nitroglycerin we have a thor-

oughly reliable and efficient stimulant in all cases of shock, surgical or traumatic, in failure of the heart's action during chloroform narcosis, and in many other similar conditions.

1519 John Street.

THE RECOGNITION OF EYE-STRAIN BY THE GENERAL PRACTITIONER*

BY EDWARD JACKSON, M. D.,

Professor of Diseases of the Eye in the Philadelphia Polyclinic.

The attempt to give relief from the symptoms of eye-strain by a careful trial *seriatim*, of one's favorite sedative, tonic, and alterative prescriptions, followed by experimentation with the formulae of great professors found floating on the surface of medical journalism, does not usually bring much comfort to the patient or credit to the doctor. And that it is so frequently persisted in until the patient deserts his so-called medical adviser, and of his own notion takes his chances with the specialist or the charlatan, seems to argue an inability to recognize the connection of this group of symptoms with their cause. The worst evil of specialism is ignorance and indifference as to other departments of medicine: one of the most aggravated manifestations of this evil is the expressed indifference of so-called "general practitioners" toward the anomalies and diseases of the eye.

From time to time efforts have been made by ophthalmologists to secure a more general recognition of eye-strain on the part of the mass of the profession; but usually these efforts consisted in a recommendation of some special instrument or procedure of diagnosis, as the refraction ophthalmoscope, or the shadow-test, or a set of trial lenses, re-

duced in size and price to the supposed needs of the mass of the profession. If it were really necessary to apply such special means of diagnosis in order to recognize the presence of eye-strain, there would be little prospect of its early general recognition. But it is frequently recognized by the patient himself, and the ophthalmic surgeon finds in the general rational symptoms quite sufficient grounds for a provisional diagnosis; and if the mind is clear from preconceived hypotheses as to the causes of the symptoms, tending to divert attention from their real origin, there is no reason why anyone respectably qualified for general practice of medicine should not be able to make a provisional diagnosis with sufficient certainty to serve for the basis of further investigation and treatment, in the great majority of cases, without resort to any special method of examination whatever. Of course, the ophthalmoscopic evidence of ametropia, when it can be obtained, is very valuable as confirming such a diagnosis; and I do not underestimate the value of the ophthalmoscope to the general practitioner, for I cannot regard anyone who is unable to use the ophthalmoscope as properly qualified for general practice. But I do say that inability to measure refraction with the ophthalmoscope is no reason for failing to recognize eye-strain.

The patient suffering from eye-strain comes with a certain history and certain complaints, which, carefully considered by the light of a very moderate knowledge of the subject, clearly indicate the cause of the trouble, in the great majority of cases. The symptoms in question may be considered separately.

Impairment of Vision, either quite temporary, more prolonged, or quite permanent. A very characteristic form of temporary impairment of vision is that due to sudden relaxation of the accommodation. This occurs when the ciliary muscle has long been overtaxed, and especially in the latter hours of the day, when it is nearly tired out. The patient notices that the print or other near object on which the

*Read before the Philadelphia County Medical Society, June 25th 1890.

attention is fixed, suddenly becomes entirely blurred, compelling the cessation of the eye-work. After a moment, however, the power of again focussing the object returns, and work can be resumed. The patient is apt to close his eyes for an instant, and, perhaps, rub them, and on again opening finds the sight again restored. If the eye-work is continued, the failure of accommodation recurs, to again rapidly pass away; and keeping on with the eye-work, these periods of inability to see become more and more frequent, until, finally, they greatly interfere with the continuance of the work or quite prevent it. This form of impairment affects only the vision for near work.

Another temporary impairment is that due to spasm of the accommodation, it affects distant vision only, and is noticed chiefly by those whose distant vision is otherwise pretty good. It comes on after prolonged straining of the eye, usually for near vision, and lasts until the eye has gotten well rested. It is a valuable danger signal, and should secure cessation from the work causing it until it has given place to normal relaxation. Permanent impairment of vision is brought about when eye-strain causes myopia or decided permanent damage of the choroid and retina.

Headache and aching of the eyes.—Eye-strain should be the first thought suggested by any complaint of headache, for in our day and civilization it is by far the most common cause of that symptom. It enters as a factor into the causation of nearly all headaches not due to pyrexia, toxemia, or diseases of the brain or its membranes. The simple existence of headache, therefore, should suggest eye-strain; but frequently a careful inquiry as to the manner and time of occurrence of the attack, and the location of the severest pain, will be almost conclusive as to the origin of the trouble.

Often it comes on whenever the eyes are used, and is absent when they have had a proper period of rest. The occasions of most severe requirement in the

direction of eye-work are the doing of anything requiring accurate near vision, taxing both the accommodation and the convergence; or travelling, shopping, attendance at public gatherings, which entail more use of the eyes than the patient is at the time conscious of, and often under unfavorable conditions.

Very often the chronological connection between the use of the eye and the occurrence of the ache, although perfectly certain and evident when once it has been observed, has never been noted by the patient until his attention has been directly called to it. Even when the headache seems constant and quite uninfluenced by variations in the amount of eye work, it may be due wholly to eye-strain.

In hyperopia in young people the accommodation is in excessive use so long as the eyes are open and the attention fixed on any visible object; and hyperopia is the most common cause of constant headache. The writer was formerly subject to a constant headache whenever confined to the house, and regarded it as caused by breathing vitiated air, until it was quite cured by the correction of his hyperopic astigmatism. Many persons have the same idea as to the causation of the headaches they always experience when attending the theatre or other place of public amusement, and which are really due to eye-strain. Others ascribe these headaches, and those experienced in travelling or shopping, to exhaustion. This is nearer the truth, only they commonly have in mind a condition of general exhaustion, whereas it is largely one of local exhaustion of the special nervous apparatus concerned in the act of seeing.

The *location of the aching* is of some significance. Generally it is frontal, often described as beginning in the eye, or just back of the eye, or through the temples. Frequently it extends to the occipital region, and may sometimes be felt principally or wholly in that region. Headache most severe in the vertex or confined to that region is probably not

very common from any cause, but from eye-strain it is almost unknown. Often the headache is more severe on one side of the head than the other. Sometimes it is entirely confined to one side, but usually it is bilateral.

Those more or less regularly periodical headaches, known as nervous or sick headache, migraine, or, when confined to one side of the head, hemicrania, are in many cases set up by eye-strain and relieved by its removal. Attacks of this kind are frequently ushered in by certain interference with vision and subjective sensations of light, affecting a part or the whole of the visual field, and known as ophthalmic migraine. These visual disturbances are simply a part of the general "nerve-storm," and it is not certain that they especially indicate the origin of the attacks to have been eye-strain.

Congestion, irritability, or inflammation of the eyes and their appendages should always suggest the suspicion of eye-strain. A single attack or manifestation of this kind has no especial significance, but repeated attacks of inflammation, or prolonged congestion or irritability, are exceedingly suggestive of a continuing cause; and the most common of these is the one under discussion. No case of chronic inflammation of the margins of the lids, or of recurring conjunctivitis, or repeated styes, has justice done to it until it has been carefully investigated for eye-strain. Persons at the period when they begin to feel the effects of loss of accommodation in presbyopia or absolute hyperopia, suffer from repeated attacks of conjunctivitis which they commonly ascribe to "taking cold in the eye," but which are cut short by use of the appropriate lenses, and which, if unchecked, would tend to establish a chronic catarrhal condition which is a chief discomfort in the lives of many elderly people.

Of course, these conditions of ocular congestion and inflammation will be recognized by the usual symptoms of redness, swelling, and itching, smarting, or burning pain. They often require especial

local treatment, and will quite often be temporarily cured by this alone; but if the underlying cause is not removed, they show a strong tendency to recur indefinitely, or until the accommodation is so far lost that the temptation to restrain it is removed. It should be noted that usually headache and these inflammatory conditions are not presented by the same case. They may coexist, but, more commonly, if one is decidedly present, the other is absent.

So far nothing has been mentioned for the diagnosis of eye-strain but the facts ascertained by questioning the patient, and from simple inspection of the eye. If, now, the physician's office contains—what every general practitioner's office should contain—a card of test-letters for accurately ascertaining the distant vision and a card of fine print for ascertaining the near point of the eye, additional valuable evidence is easily obtainable. The trial of the distant vision will give indication of any considerable degree of myopia or astigmatism. But it must always be borne in mind that troublesome ametropia may be present without preventing perfect distant vision. The position of the near point, if farther from the patient's eye than his age would indicate, is pretty good evidence of strain of the accommodation. Evidence of strain of the external muscles of the eye, heterophoria, can be obtained by simply getting the patient to keep his eyes fixed on some object, near or distant, and covering one eye; then noting whether the covered eye deviates from its position of fixation, and especially whether it makes a quick movement to return to that position when it is uncovered.

Briefly to recapitulate, the common symptoms of eye-strain are:

Certain forms of impairment of vision. Headache, which is to be studied with reference to the times of its occurrence and the parts of the head to which the aching is referred, with careful discrimination between the patient's facts and his theoretical explanation of them.

Chronic or repeatedly recurring con-

gestion, or inflammation of the eye or its appendages.

And if to these symptoms are added the results of the simple tests of near and distant vision, and evidence of tendency of the eyes to deviate from their normal position when covered, a very good basis is furnished for the probable or provisional diagnosis of eye-strain, without recourse to any special apparatus or unusual diagnostic procedure. And in view of these facts there is no justification for the general practitioner who fails to recognize most of the numerous cases of eye-strain with which he is brought in contact.

ON THE USE OF IODOFORM IN THE TREATMENT OF SUMMER DIARRHœA OF CHILDREN.*

BY J. B. SAUNDERS, M. D., OF BALTIMORE.

Mr. President and Gentlemen:—It is with confidence, and only after deliberate reflection, that I have consented to make to this Society a report of my experience with iodoform in the treatment of summer diarrhœa of children.

In the summer of 1886, after a year's experience "as Chief of Clinic for Diseases of Children in the City Hospital Dispensary," with the ordinary and accepted treatment of diarrhœa, I tried to think of something that would give more satisfaction, would relieve the suffering of those poor children more quickly than the means in my hands.

A thought struck me, why not use iodoform? My idea of the cases seen was that the intestinal tract of the children was in all stages from simple irritation to almost deep ulceration, and knowing the good effect of iodoform when used outside of the body, I could not see any objection to the use of it internally. Its action is that of an astringent, disinfectant and germicide. It is almost insoluble. After deciding to use the remedy, the first thing to do was to make it acceptable to the

stomach and keep it from causing the nausea that it will do if used of itself. This was happily found in the bismuth subnitrate, and as there is usually pain found in the trouble, some form of opium is always necessary, in my judgment the pulvis opii et ipecac. or Dover's powder is the best form to use in this trouble.

Still a great trouble in my way was the smell of the medicine which to many persons is very disagreeable. This was of course greater in private practice. I experimented for nearly a year before I was able to destroy the odor of the iodoform without also destroying the chemical composition of it. The means to do so was found at last by accident and is the common coffee bean, 2 grains of which will destroy the odor of 2 grains of iodoform, and as the finely powdered coffee is bland, and not irritating, it may be used with impunity.

As is usually the case when a man gets a hobby he rides it to death. For the first year any case coming under my notice with diarrhœa was sure to get iodoform.

Cases of gastritis, gastro-enteritis, entero-colitis or colitis or in fact anything that I thought might get diarrhœa got iodoform, and strange to say the result was about the same as with older and tried treatment.

Since that time I have tried always to pick my cases and use more rational treatment. I use the remedy now only for gastro-enteritis and entero-colitis, and am assured of the decrease in the mortality since 1886. I have treated about from 800 to 1,000 cases in the dispensary and asylum work with a percentage of deaths that amounts to about $4\frac{1}{2}$ per cent., the smallness of which I think is due to the treatment.

For gastro-enteritis I invariably commence treatment with a calomel purge, and prescribe the following for a child of say, six or six and a half months of age:

R	Iodoform	gr. iii-iv
	Bismuth. subnit.	" xii

*Read before the Medical and Surgical Society of Baltimore May 22nd, 1890.

Pulv. ipecac. et opii gr. xii
M. Ft. Chart. vi.

Sig. One every two hours, and increase the dose according to age of child.

With this treatment I make careful inquiry as to the food, and give strict orders concerning the clothing and insist on the daily bath, and the trouble usually lasts two to three days. In some cases you will find tongue and mucus membranes dry, then it is of service to add to each powder $\frac{1}{2}$ of a grain of calomel. My attention was called to the possible danger of making an extemporaneous biniodide of mercury, by Dr. Gardner, but I have never seen any trouble caused by it, and in the four years, constant use of iodoform internally, I have only seen two cases of iodoform poisoning; those two made good recoveries.

In entero-colitis, I use very nearly the same treatment, except where there is much tenesmus, I use the rectal injection of starch water, in which is suspended from one to five grains of iodoform with twelve drops of laudanum.

In conclusion I would like to state that I believe the virtues of iodoform for diarrhoea are not justly appreciated, and if it had a more general trial the profession would find in their old friend a most useful ally to stamp out the worst enemy the children of a crowded city have to contend with.

819 East Chase Street.

Society Reports.

PHILADELPHIA COUNTY MEDICAL SOCIETY.

STATED MEETING, HELD JUNE 28TH, 1890.

Dr. Edward Jackson read a paper entitled

THE RECOGNITION OF EYE-STRAIN BY THE GENERAL PRACTITIONER.

(See page 284.)

In the

DISCUSSION

which followed:

Dr. George M. Gould said: Certainly, nothing Dr. Jackson has advanced in his excellent paper calls forth controversy or criticism; but I think a word may be added as to other certain symptoms not alluded to by him that may sometimes put the general practitioner on the track of an eye-strain reflex. When eye strain is sufficiently severe to set up a reflex neurosis, sleepiness is a common symptom brought on by persistent reading or writing. The patient cannot understand why he grows so drowsy. A more important trouble is one I at first advanced somewhat doubtfully, but now I am growing perfectly convinced is a genuine result of ametropia. I allude to troubles of appetite and digestion. Few patients with severe or long-continued eye-strain that do not complain of anorexia, fickle appetite, or some dyspeptic trouble Mothers frequently call such girls "pickers." Explain the mechanism of this reflex as we may, I am sure it is a fact, and that a malnutrition often results that may end in anaemia and many different forms of nervous abnormality. I have had a large number of such patients regain long-lost appetite after putting on glasses, and regain ten to twenty pounds of flesh within a month or two. Nervousness and choreic movements, even genuine choreas, are traceable sometimes to the same causes. I had one patient who wore the right shoe out in a few weeks, and who had a habit of bursting out crying or into a rage at a trifle. She had been treated for chorea for years at one of our best hospitals. All symptoms have disappeared for two years upon correction of her hyperopic astigmatism. I could cite several other cases.

I should like, also, to call attention to car-sickness in connection with eye-strain. I have had eight or nine cases of this kind, and by glasses all have been relieved of the car-sickness. One case was that

of a gentleman who on every journey had car-sickness. While he had the mydriatic in his eyes he went to Washington, and suffered no inconvenience whatever. Subsequently, after he had glasses, he made a trip to St. Paul without any of the former trouble. In the last two days I have two cases—one that of a girl who could not ride a short distance in the street cars without vomiting. I found a decided degree of hypermetropic astigmatism. With the mydriatic in her eyes she rode home without her usual trouble.

A strange thing with reference to eye-strain is, that it often exists to an exceptional degree without showing any symptoms in the eye. The patient will often say that the eyes are perfectly good and have never caused any irritation. The reflexes seem to settle in some other place. This is an interesting pathological and physiological question.

With reference to testing the eyes by the general practitioner, it has struck me that a simple plan, which could be readily carried out, would be as follows: Have two test cards, so that the patient will not learn and remember the letters. Let him first test distant vision with one of the test-cards; then let him instil homatropine. This will give perfect paralysis in three-quarters of an hour. Then retest with the other card. Then, if vision has decreased, there is eye-strain, due to astigmatism or hypermetropia. Another practical point is that, if the patient is suffering with headache, he will be relieved by the application of the mydriatic. It is as to the existence of hyperopia and astigmatism that we want to know. Myopia rarely produces eye-strain.

Dr. Mary E. Allen said, I would ask if, in these cases, the condition of the recti muscles has not something to do with the symptoms? In my own case, I suffered eye-strain for a long time, and insufficiency of the recti muscles. I had one symptom which I have never seen described, and that is, a feeling as though a blow had been struck against the eye.

My explanation of this is that, by a spasmodic contraction of the straight muscles, the elastic eye-ball is suddenly drawn with force against the back of the orbit, giving the sensation of a blow. I had this a long time before wearing glasses, but very seldom since.

Dr. Jackson said my paper simply refers to the *recognition* of eye-strain. I purposely considered only those symptoms most generally present, and had in mind the great mass of cases, not the exceptional ones, which do, in the aggregate, constitute a very large number, but still are proportionately few. The other symptoms which have been mentioned, and many others, might be referred to as due to eye-strain, but they do not occur in the large number of cases, and can hardly be regarded as of general importance in making the probable diagnosis.

I have used the term eye-strain, not as a synonym of ametropia, because we may have ametropia with eye-strain or eye-strain without ametropia, if requirements are put upon the eye too great for its capacity. You can have it without any ametropia or weakness of any extra-ocular muscle or group of muscles. It is to the question of eye-strain as isolated and separated from ametropia that I refer. Of course, in a very large proportion of cases, the relief of the eye-strain comes from correction of the ametropia.

In connection with that correction, I should like to say one thing with reference to a remark made by Dr. Gould—that is, if myopia were present, it need not be considered. In my experience, myopia may cause severe eye-strain. There is the strain of convergence, and any inequality between the two eyes in the amount of myopia—and myopia is usually unequal—is very likely to cause eye-strain. The discovery of myopia would not, to my mind, rule out the existence of eye-strain.

Dr. H. O. Hanawalt, one of the best-known physicians in the West, has been elected Professor of Diseases of Children in the Kansas City Medical College.

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BALTIMORE, AUG 2, 1890.

Editorial.**THE CLINICAL MEANING OF CLAY-COLORED STOOLS.**

When, as the result of disease, the bile does not enter the intestines nor mix with the faeces, the normal brown color of the faeces no longer appears and the faeces become of a white or whitish color.

In certain cases, however, there is no hindrance to the secretion of the bile nor to its escape into the intestines, and yet the faeces are white or whitish. To the condition of this class of cases Dr. Walker devotes a very interesting article in the *London Medico-Chirurgical Transactions* for 1889. According to this writer, who fortifies his position by quotations from standard physiological works, the insuffi-

ficient coloring of the faeces is, in such cases, the result of the absence of *pancreatic fluid* from the intestines, the secretion of the fluid being prevented or its effusion checked by some abnormal condition of the pancreas or its ducts.

Under ordinary circumstances a large portion of the bile which is poured into the intestines is absorbed again by the intestinal walls, while another portion of the bile is acted upon by the pancreatic juice, which it meets in the intestines. The result of this action is that the bile pigments are no longer capable of being absorbed by the bowel walls, but form with the pancreatic juice the brown pigment which colors and passes out with the faeces. When no pancreatic juice is present the whole of the bile may be reabsorbed and thus the stools may be left colorless. Dr. Walker quotes two cases in support of his views. In the first case a robust, active physician of 65 years began to suffer from epigastric pain, looseness of the bowels and general debility, the stools soon becoming colorless. The other symptoms disappeared, but the patient continued to pass large colorless stools of a rather putrid than foecal odor. At first, disease of the liver was suspected, and later the appearance of oil and fat in the stools led to the belief that the pancreas was implicated. After this condition had persisted for 14 years, the patient passed through an attack of pneumonia, with slight jaundice and with symptoms pointing to pyæmia. He survived this attack ten years, the stools continuing to be large, putrescent, greasy and clay-colored. He died at the age of 91 of cystitis and orchitis. At the necropsy the liver and bile-ducts were found to be normal, and there was some bile in the gall bladder. The pancreas

was degenerated and its duct was completely occluded by a calculus, an inch from the duodenum.

The other patient was thought to have chronic phthisis, but the appearance of large, loose, greasy, pale evacuations pointed to pancreatic trouble. He had had glycosuria. Jaundice was not observed. After some years, during which the stools remained abnormal as before, he died. After death the lungs were found to be diseased. The liver was normal; the bile-ducts were pervious and contained normal bile. The pancreatic duct was completely occluded by an old cicatrix of the bowel wall.

Dr. Walker proceeds to show how his views explain the puzzling phenomena of *icterus neonatorum* and also the peculiar action of calomel in cases of so-called "biliousness." Although experiment teaches that calomel and like purgative salts of mercury do not increase the secretion of bile but rather diminish it, yet it is certainly true, as Ringer says, that such mercurials will restore the normal color to colorless stools. Dr. Walker explains these contradictory observations by supposing that the cause of the paleness is the absence of the pancreatic fluid, and that the mercurial restores the color by causing an outflow of pancreatic juice into the intestine. His view is rendered more probable by the known similarity in action and sympathy between the pancreas and the salivary glands, the latter of which are known to respond readily to the influence of mercury.

In each case of colorless stools the physician should, therefore, determine first whether the liver or the pancreas is the organ at fault and direct his therapeutics accordingly.

The article is a very striking one, and sheds light upon several dark problems of clinical medicine. Dr. Walker deserves the thanks of every practitioner.

THE TREATMENT OF POISONING BY ILLUMINATING GAS, WITH NITROGLYCERIN.

Although illuminating gas has been in use for so many years, it falls to the lot of almost every practitioner to treat a certain number of misguided persons, who, through ignorance or drink, persist in blowing out the gas, or else in turning it on after the light has been extinguished. The effect of long exposure to illuminating gas has been shown to be disintegration of the oxyhaemoglobin and the displacement of the oxygen by carbonic oxide. The various forms of treatment in use now are all directed to stimulation, but this can be of little use as the large number of deaths from this accident showed. Bleeding was resorted to, but this again is not without danger.

Dr. W. C. Kloman (see page 281) has now treated several cases successfully with nitroglycerin hypodermically, and the quick action and satisfactory results of this treatment on his hands apparently leaves little to be desired. It is a great convenience to have a remedy so easily portable, so conveniently administered and generally so quickly effective as nitroglycerin in combatting these cases, that the physician should not fail to provide himself with the hypodermic tablets of nitroglycerin in his emergency case ready for immediate use.

Correspondence.**LONDON LETTER.**

LONDON, July 2nd, 1890.

Editor Maryland Medical Journal:

DEAR SIR:—You exacted a promise of me on leaving home, that I would write to you. I am now reminded how slow we should be to make promises; but as I did it, and as I have many medical friends in Maryland who would be pleased to know where I am, and what I am doing, I will send you this scribble and ease my conscience.

I sailed in the "City of New York" on Wednesday, June 18th, with my friend, Dr. J. J. Chisolm, as my roommate and travelling companion. We sighted Fastnet light on the following Tuesday afternoon at five o'clock, when the sea-sick ones revived, and the dubious ones took courage. Twelve physicians were on board, all clever fellows, so that we had a charming medical society, at which we discussed medical subjects and reported cases, day by day, save when some had surrendered to Neptune, or were struggling to resist his powers.

Two of these gentlemen—between 40 and 50 years of age—were on their way to Birmingham to place themselves under the tuition of Mr. Lawson Tait for three months. They pay him \$300 for this time, and have the privilege of seeing him do his operations, but do not see the patient before she is brought in the operating room, or after she is removed from the same. He takes, I am told, four lookers-on at a time, for which he is paid about \$100 per month. I have recently seen a gentleman from America, who has lately been one of his pupils, as above described; and he tells me many things of Mr. Tait's wonderful ability with his fingers, scalpel, and scissors. So far as results are concerned, he could tell me nothing, for he was never allowed to see a patient, after the operation.

On landing, Dr. Chisolm and I went to Eaton Hall, at Chester, the Duke of Westminster's most magnificent estate; forty thousand acres in the tract, and three hundred and fifty deer in one herd. The present Duke has spent ten million pounds sterling on this estate since his incumbancy.

From Chester we went to Glasgow, to see the great ship yards on that remarkable stream, the Clyde, so narrow that a stone may be thrown from one side to the other. We were conducted through the yard of Sir Wm. Pearce by a guide placed at our disposal and shown every department of iron ship-building, from the laying of the keel to the completion of the engine. Six immense iron ships were in course of construction. Four thousand hands are employed. Here were built the Etruria and Umbria.

From here we went to Edinburgh, one and a half hours ride by rail, the most beautiful city in the world, except Stockholm; but it is a bad city in which to be sick on Sunday. As we were told by the porter of our hotel, everything is closed here on Sunday, except the churches, even the drug stores. Street-cars stop, cabs stop, except here and there, one or two for special service. Externally, the Sabbath is more strictly observed in Edinburgh than in any city I have ever seen, and yet I have seen more drunkenness here, on one Saturday afternoon, than during my travels through many countries on the Continent of Europe.

I was unfortunate enough to be sick on Sunday, and Dr. Chisolm, ever ready to serve a friend, went out to get some medicine for me, and but for his indomitable will and energy, I should have had to suffer on till Monday morning without it. After walking several miles, making many inquiries, and ringing many bells, he was able to squeeze through a narrow opening into one drug store and when he asked the druggist for an anodyne, he was told that such medicine could not be sold to common people. After some explanation, that he was a doctor, and the medicine was wanted for a doctor, that

that we were no common people but citizens of America, where every man is a sovereign, the medicine was doubtlessly given. The moral is, "Don't get sick in Edinburgh on Sunday." I am not informed whether the doctors close their offices on this day, but the druggists do.

At the Royal Infirmary I saw Dr. Alexander Simpson, assisted by Dr. Berry Hart, do a laparotomy. The case was a dermoid tumor, in a patient, upon whom Dr. Thomas Keith operated nine years before for a cystic tumor of the other ovary. Remarkable in abdominal surgery.

About fifteen persons, nurses and others, were present, in a small room, with one ordinary window. Evidently Dr. Simpson does not believe that presence of many persons enhances the dangers of an operation. Neither do I. We are all fast coming to the conclusion, that strict cleanliness, about and within the abdominal cavity, and not the use of antiseptics, is the secret of success in abdominal surgery.

Drs. Simpson and Hart are warm-hearted gentlemen.

Dr. Chisolm and I were invited to Dr. Simpson's country seat, and to dine with each of them, but our time was too short, we were off for London, whither we were taken by the "Flying Scotchman" at from fifty to sixty miles an hour.

Faithfully Yours,
H. P. C. WILSON, M. D.

Reviews, Books and Pamphlets

Mineral Springs and Health Resorts of California, with a Complete Chemical Analysis of every Important Mineral Water in the World. Illustrated. A prize essay. Annual prize of the Medical Society of the State of California. Awarded April 20, 1889. By WINSLOW ANDERSON, M. D., Joint Editor and Publisher of the *Pacific Medical Journal*. San Francisco.

The Bancroft Co., 1890. Pp. 284.
Price \$1.50.

Although this book contains principally, a history and description of the California springs, still a chemical analysis of all the important mineral springs of the world is added, and a comparison of the most important principal ingredients will show each spring's virtues. Of course, many such springs are almost inert, but a few of them possess remarkable medicinal properties, and if we could obtain a good history of all the mineral springs of this country, written by one not too interested in their financial popularity, the American profession would have a powerful addition to their armamentarium. While there is much humbug in the use of mineral waters, and more empiricism, still the good that is obtained from the strict diet and regimen followed at the best known foreign spas should incite us to develop our naturally rich resources to their utmost. Dr. Anderson has given some valuable hints in his book, and although this work can hardly be called a scientific production, still if a writer in each State would produce a similar book, the history of mineral waters in this country would be very complete.

Extra-Uterine Pregnancy; the History of, by DR. G. W. MILTENBERGER; Laparotomy for, with Report of a Successful Case; by DR. T. A. ASHBY; Review and Discussion, by DR. H. A. KELLY. General Discussion. Papers read before the Obstetrical and Gynaecological Society of Baltimore City, January 14th, and February 11th, 1890. Published by order of the Society.

This little brochure shows what excellent work the Obstetrical and Gynaecological Society has done in the past year. The subject of extra-uterine or ectopic pregnancy, is so interesting at the present day that it is a pleasure to read these valuable additions to its literature by men of ripe experience and no mean

learning. The papers of Drs. Miltzberger and Ashby seem to be the result of personal experience. Dr. Kelly's paper is particularly interesting on account of the literary references and excellent cuts.

Another Hitherto Undescribed Disease of the Ovaries. Anomalous Menstrual Bodies. By MARY A. DIXON JONES, M. D., Brooklyn. Reprinted from the *New York Medical Journal* for May 10th, and 17th, 1890.

Gunshot Wounds of the Abdomen. By AUG. SCHACHNER, M. D., of Louisville. Reprint from *Annals of Surgery*, June, 1890.

Programm für den X. Internationalen Medicinischen Congress zu Berlin, 4-9, August 1890.

Miscellany.

MENTAL OVERWORK IN MODERN LIFE.

Doubtless the age in which we live is peculiar, in the sense that multitudes are obliged to toil harder with their brains than any other race. Never before, perhaps, in the history of mankind did arduous strife and competition, involving the higher nervous energies, become so necessary. The present generation is the heir to all the acquisitions of the past, but these have been an ever-accumulating burden, which is almost too great for the strong to bear, while the weak and exhausted must succumb beneath the load, though the latter be no more than just sufficient to equip its possessor for a fair chance in the struggle for existence.

It has been said a hundred times, and cannot be too much reiterated, that many of the conditions of our modern life are unfavorable to the best physical and mental development; that a sedentary life stunts and dwarfs the muscular powers, while constant study, without physical exercise, dwarfs and dulls the in-

tellect; that overwork of every kind exhausts the organs and tissues concerned in such overwork; that the fruits of overschooling and intense competitive examinations are seen everywhere in the neurasthenia and premature decay of the present generation.

It has been proved, however, that hard study can be borne with impunity, provided that sufficient physical exercise be taken. This is a truth which the literary man and the student should ever have in mind. We have a good instance of this in the life of the late Frenchman, Littré, one of the most indefatigable literary workers of this age. His habit was to spend most of the day out of doors in physical recreation and in exercise; and he only began his studies and his writing about seven o'clock in the evening, when he would enter his library and pore over his books, absorbed in study, or bend over his writing-desk, working without cessation, till three or four o'clock in the morning, when, yielding to fatigue, he would seek a few hours refreshing sleep.

It is well known that many of the most noted writers in the medical profession have been men who have diligently kept good their physical powers while performing an enormous amount of brain-work, we need only instance such professional lights as the late Dr. S. D. Gross, Dr. Austin Flint, Sir Thomas Watson.

At this season of the year, to business men, students, and professional men, this advice is opportune, and, however, trite, needs emphatic repetition. Take suitable vacations. Don't let the muscles become toneless and atrophied from disuse. Seek frequent occasions for breathing mountain air or sea air; leave the city and go to the country. The flagging mental powers are best rallied and quickened by change, recreation, and physical exercise.

Physicians above all others often feel that they cannot afford to go away from home for even a short vacation; but such economy is short-sighted and deplorable.

In a recent spirited publication,* Marie

*"Le Surmenage Mental dans la Civilisation Moderne." Translated from the Russian. Paris, 1890.

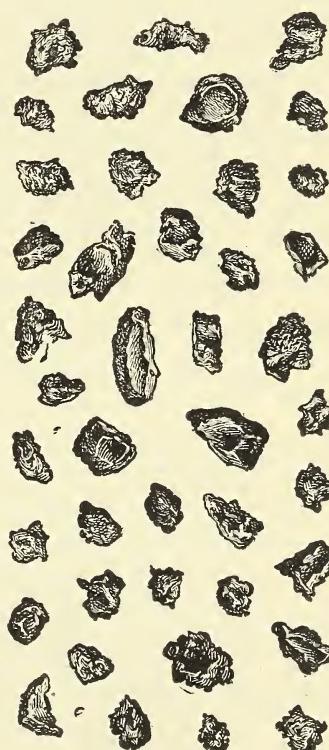
Manacéine, whom we may call the Mary Somerville of Russia, has traced the causes, effects and remedies of mental overpressure in modern life. She lays great stress on the want of gymnastic training in schools and the numerous unhealthy conditions of our civilization. The besetting infirmities of the age are "cerebral anaemia" and "nervous exhaustion." The causes are complex, but they all act similarly,—"by producing irregularities in the vascular sphere;" *i. e.* by impairing the tonus of the cerebral blood-vessels. "When once the tone of the blood-vessels is lost, when the nutrition is disturbed, and the circulation no longer responds to the exigencies of normal life, phenomena of dissolution begin to manifest themselves."

To this want of tone a variety of causes conduce,—the quality of the ingesta, excitement, worry, excessive application of mind, etc. Mlle. Manacéine regards the stimulants (tea, coffee, alcohol, tobacco, etc.) in which the people of the age are prone to indulge as being large factors in producing a toneless condition of the cerebral vessels; but exhaustion by over-work, and especially by worry, are doubtless still more important factors.

As remedial agents, besides avoidance of the causes, Mlle. Manacéine assigns great importance to gymnastic and other physical exercises, and to hydrotherapy. Cold douches and bladders of ice to the head have given some excellent results. Should the professional man drink wine, tea, and coffee? it is asked. There is scientific evidence that these beverages (and especially spirits,) if taken in any excess, do favor arterial degenerations, or, at least, that cerebral plethora, which finally forces the tonus of the blood-vessels. Hence the proper counsel would be moderation or abstinence. The evils resulting from excess are undisputed. In this age of excitements and unrest there is an importunate demand for stimulants of all kinds, but he is the wisest and happiest man who can live calmly and at ease without them.—*Therapeutic Gazette.*

BUFFALO LITHIA WATER, A SOLVENT OF STONE IN THE BLADDER.

Mr. R. L. Roys, of this city, consulted me about two years ago for stone in the bladder, from which he had been suffering for a number of years. On my suggestion he commenced the use of the Buffalo Lithia Water as he was very much opposed to operative interference. After using the water for a short time, disintegration to a certain extent took place and large quantities of stone were passed. For several days in succession, he passed as much as a teaspoonful of the debris and at intervals, for a considerable period he passed large quantities, and under the continued use of the water, there was a constant passage of calculi until he was entirely relieved of his trouble.



The photograph sent herewith is a correct representation, and exact size of some of the largest specimens of calculi

discharged by Mr. Roys. A chemical and microscopical analysis showed that they are uric acid with a trace of the oxalate of lime.—Dr. C. H. S. Davis, in the *New England Medical Monthly* for July, 1890.

THE CHOICE OF ANÆSTHETICS.

In view of the lesson taught by statistics it seems surprising that European surgeons should still keep up their allegiance to chloroform as their favorite anæsthetic. While it is true that this agent possesses a number of advantages which may render its use preferable under certain conditions, there can be no gainsaying of the fact that ether is by far the safer anæsthetic of the two. The results of the late Hyderabad Chloroform Commission, to which so much weight has been attached in some quarters, have really shed no new light upon this subject. They cannot be regarded as having proved the assertion made in an English journal that deaths from chloroform can be avoided with certainty by due care in its administration. American surgeons will be slow to accept conclusions based upon experiments made on dogs, and ignore the teachings of practical clinical experience. Moreover, these clinical data are completely in harmony with the observations of such careful and competent experimenters as Professors H. C. Wood and Hobart A. Hare, of Philadelphia. These observers reiterate the view generally accepted in this country that chloroform always produces death by cardiac paralysis, and not as the English experimenters claim by respiratory failure. To the practical surgeon, however, it matters little whether the Indian dogs experimented upon by the Commission are differently affected by the administration of chloroform than the American canines; what he is chiefly interested in, is the question as to the relative safety of the anæsthetics in human beings. And, as has been already stated, fatal results are much less likely to follow the administration of ether than of chloroform. More than four

hundred deaths have been recorded from the use of chloroform, and many of the cases occurred in the practice of surgeons whose reputation is a sufficient guarantee that the anæsthetic was carefully administered. It is also a significant fact that most of the European surgeons who have taken up their residence in this country have become converts to ether anæsthesia after a trial of both agents.

The subject of the choice of anæsthetics was recently discussed at the Congress of the German Surgical Society, and, to judge from the tenor of the discussion, it would appear that the superior advantages of ether are becoming recognized by an increasing number of German surgeons. Professor Burns, one of the speakers, contrasted the full and strong pulse observed during ether anesthesia with the small and feeble pulse present during the administration of chloroform; and stated that the sphygmographic tracings which he had taken were confirmatory of the view that chloroform, unlike ether, is a cardiac and circulatory depressant.

In conclusion it may be said, that while the dangerous effects of chloroform may be obviated to a certain extent by scrupulous care in its administration, there exists a large number of cases in which its tendency to produce cardiac paralysis may give rise to the most disastrous consequences. Aside from certain well-known conditions, therefore, in which the superior advantages of chloroform have always been admitted, this anaesthetic should be supplanted by ether in general surgical practice.—*International Journal of Surgery*.

HOW TO REACH AND ENJOY OLD AGE.

It is no simple matter to state in terms at all precise what forces are directly connected with the production of hale and happy old age. More certainly is involved in the process than mere constitution. Healthy surroundings, contentment, and active, temperate, and regular habits are most valuable aids. Hard work, so long at least as it is not carried

beyond the limit necessary to permit of the timely repair of worn tissues, is not only a harmless, but a conducive circumstance. It is, in fact, by living as far as possible a life in accordance with natural law that we may expect to reap the appropriate result in its prolongation. Civilisation is at once helpful and injurious. Under its protecting influence normal development at all ages is allowed and fostered, while the facilities it affords for self-indulgence are constantly acting in an opposite direction. The case of Hugh Macleod, aged almost 107, which has lately been published, illustrates in a remarkable manner the truth of these observations. This man, a Ross-shire Highlander, in what must be the sombre twilight of a blameless and fairly active life spent in his native county, still shows, it is said, a notable degree of vigour. He takes a lively interest in the affairs of life, has good appetite, is generally healthy, cuts and carries his peat for household use, and goes about among his neighbours as of old. His food is of the plainest though nutritious—porridge, fish, a little meat; and his habit in this and other matters is not unworthy the attention of many who are daily hastening by opposite courses the end of a merrier, shorter, but perhaps not happier life.—*Lancet.*

A SUGGESTION IN PULMONARY CONSUMPTION.

A suggestion of some interest, whether it be available or not, is that made by Richard Reuter, in the *Cent. f. die ges. Therap.* He states that he has been working in practical chemistry since 1863, a large part of the time as manager of various large manufactories of metal wares, in which the articles as manufactured were electro-plated, either with gold or silver. Here he noticed that many of the people employed in the electro-plating departments were at the beginning delicate and sickly, since the work did not require of them much exertion, but afterward gained rapidly in flesh and felt better in many ways.

He was at first inclined to attribute this change principally to the fact that the work was probably lighter than that to which they were accustomed, but afterward observed that the effects were greater than could be attributed to this cause alone. Persons apparently suffering with heart affections, but especially those having a consumptive appearance, even those with a bloody expectoration, found marked relief after working in these departments a short time, the chest pains and dyspnoea became less, the cough became less frequent, the expectoration grew less in amount and was more easily coughed up, in short, the workmen made rapid progress toward health, they improved in appearance and gained in weight. These favorable results were seen in male and female employees of various ages, in whom the pulmonary affection was so advanced as to be recognized by the laity.

Their condition grew worse, however, as soon as they were put to work in other parts of the building—even of a light character, or left off work entirely, and improved when they returned to their former occupation. The thought now forced itself on Reuter, and gradually changed into conviction, that these results were not from mere chance, but that they might be due to the hydrocyanic acid which is constantly being set free in these apartments.

In such establishments there are large baths in which hydrocyanic acid is constantly being developed, and its peculiar odor is quite strong where a number of baths are in operation at the same time. Reuter believes that the inhalation of the air saturated with this agent is the active cause of these salutary changes in the condition of the workmen. Even if this substance has been tried in such diseases and found wanting, Reuter believes that it is the administration by inhalation that gives quicker and better results upon the respiratory organs.

He does not share the fear that may be present in the minds of some that a violent poison, as hydrocyanic poison is

known to be, introduced into the system in the manner indicated for a considerable length of time, would work injuriously upon the organism. Within the last thirty years he has learned to know, in different establishments, more than a hundred persons engaged in this particular occupation who were not injured by it, without a single exception, and the majority of whom at the present day enjoy excellent health; none of these individuals, so far as it has been in his power to ascertain, have died while so occupied, with the exception of a few who had reached an advanced age, and of these deaths not one could be attributed to tuberculosis.

Reuter himself, was actively employed in such rooms for a number of years the whole day long, and afterward had a wookroom immediately adjoining and connecting with them by a door that was always open, but at no time did he ever experience any ill effects.

He adds that if his experience be confirmed by observers in the medical profession, it will be unnecessary to point out the simplicity and above all the inexpensiveness of this plan of treatment, which is on that account open to the very poorest.—*Weekly Medical Review*.

THE CARE OF THE NIPPLES.

The care of the nipples during the latter part of pregnancy and while lactation is going on, is a subject to which most text-books on midwifery devote a good deal of attention, advising the application of alcoholic preparations, alum, tannin and other hardening and astrigent substances with the idea of toughening the nipples so that they will be least likely to crack. Professor Parvin, of Philadelphia, however, does not believe in this hardening treatment; he contends that to harden the skin is to make it all the more likely to crack, and that treatment should be directed to keeping the nipple soft. He says that nature provides for this softening by supplying the nipple with a vast number of sebaceous

glands, whose oily secretion softens the skin and at the same time aids it in shedding water. Alcoholic preparations, by dissolving this oily secretion, defeat the purpose of the glands. Hence Dr. Parvin advises instead of the routine treatment the substitution of careful washing with plain soap and water to prevent the milk from drying on the nipples; as this removes some of the fatty matter its place may be supplied by applying cocoa butter.—*N. W. Lancet*.

THE INCUBATION PERIOD OF SCARLET FEVER.

Opinions differ widely in respect to the incubation period of scarlet fever, and one must conclude that such a period can hardly vary within such wide limits. In ten cases of this disease occurring in patients who were operated upon by Paget the period was one day in two, two days in three, and three days in three. In twelve cases of puerperal scarlet fever the period was apparently three days in nine of them. In sixteen cases in which the disease followed tracheotomy the period was apparently three days in twelve of them. In all these cases, therefore, in which the infection was associated with a continuous lesion the period was very short, in two of them being less than twenty-four hours. Apart from this form of infection, there are recorded cases in which the period of incubation was very short, varying from one to four days. Thomas considers that, as a rule, the period is from four to seven days. It would seem probable that in cases in which infection is received through a wound the period is shortened. It is possible that, in a narrow sense, there is no true incubation period of the disease, but that there is only a longer or shorter period of time in which the virus is being disseminated. This hypothesis does not, however, furnish a very satisfactory explanation of the facts in the case.—*Archives of Pediatrics*.

THE MODE OF ACTION OF PATHOGENIC BACTERIA.

Although the "germ theory of disease" is now generally accepted, and the micro-organisms themselves have been demonstrated and cultivated, little is yet known about their mode of producing diseases in their host. Various theories have been advanced, but no definite result had been obtained until quite recently. Roux and Yersin were the first to make any discoveries; they experimented with the diphtheritic bacillus of Löffler. They found that in cultures of this organism a "poison" existed, soluble in water, which possessed the same properties, when injected into animals, as the pure culture itself, producing acute nephritis, fatty degeneration of the liver, inflammatory oedema at the site of inoculation, and paralysis of the hinder extremities. The poison acted slowly, the local symptoms only appearing after several days. They obtained the poison by filtration of the broth cultures through a Chamberland (porcelain) filter and evaporating the filtrate in a vacuum. They also found that this poison is far more abundant in old cultures than in recent ones; that it is precipitated by alcohol, and that it is destroyed at 100° C., and its virulence weakened at a temperature of 58° C. Brieger and C. Fränkel have confirmed these experiments and extended them in many ways. They likewise selected Löffler's bacillus for investigation. For the exhibition of the specific poison they cultivated it on ordinary peptone broth or in broth which had been mixed with from 4 to 5 per cent. of glycerine, and 10 per cent. of serum obtained from ox blood. The culture was filtered through a Chamberland filter, the filtrate evaporated to one-third of its original bulk in a vacuum at a temperature of 30° C., and was then treated with ten times the quantity of absolute alcohol with a few drops of concentrated acetic acid. The mixture was allowed to stand for twelve hours surrounded by ice and then filtered, the precipitate being dissolved in water and again filtered. The filtrate

was then evaporated to dryness in a vacuum, and a light amorphous mass, snow white in colour, remained. This substance gave the reaction of a proteid, allied to serum albumen. It was insoluble in alcohol, and precipitated by strong mineral acids, ferrocyanide of potassium, and acetic acid. It also gave the biuret reaction, the red colouration with Millon's reagent, the xantho-proteic reaction, and turned the polarised ray to the left. This substance was extremely poisonous, and when injected into animals produced the same symptoms as the culture. Brieger and Fränkel found a second proteid in the filtrate, allied to the first in its chemical composition, but not poisonous. The above observations are a great advance in our knowledge of bacteriology, but even more valuable work has been done by Dr. Sidney Martin for the Local Government Board, the results of which he read before the Royal Society on May 22nd of this year. Dr. Martin chose the anthrax bacillus for his investigations. He cultivated it on pure alkali-albumin, filtered this through Chamberland's filter, and proved by means of the microscope and further cultivation experiments that the filtrate contained no bacilli or spores. He obtained two poisonous proteids—albumoses—which produced in mice local oedema, and in larger doses a slow death in stupor and coma. But here, however, he went further than the German observers; he found also an alkaloid, similar in action to the anthrax albumoses, but much more powerful. The chief chemical characteristic of the purified albumoses, according to Dr. Martin, is their strong alkalinity in solution; as the alkaloid is a strong base and alkaline, he suggests that the alkalinity of the albumoses is due to the alkaloid being in a nascent condition in the albumose molecule. The alkaloids form crystalline salts in the forms of needles and prisms with mineral and oxalic acids. The importance of these observations cannot be too strongly commented on; they are the first of what will probably be a long series of experiments, and will greatly

advance our knowledge of micro-organisms, and happily lead to improved methods of treatment.—*Lancet.*

SECRETION OF BLOOD INSTEAD OF MILK

Dr. Habergritz of Witebsk, Russia, reports in the *Allgemeine Medicinische Central Zeitung* a case of the secretion of blood in the breasts. The patient was a young married woman who, when she had been pregnant with her first child about six months, consulted by Dr. Habergritz as to whether the foetus was alive. He noticed some blood stains on her linen in the neighbourhood of the breasts, and on examination found that drops of pure blood could be pressed. The patient said that the bleeding had begun when she was five months pregnant, and she did not know that it was an unusual occurrence, and therefore had not mentioned it. During the rest of the pregnancy the phenomenon continued, and the patient suffered besides from two or three attacks of epistaxis. Two days before labour came on the bleeding ceased, but it reappeared in increased amount the day after. The patient was very anxious to nurse the child, but as it drew nothing but blood this had to be put a stop to. On the seventh day the colour of the secretion began to change, and by the eighth it had all the characters of ordinary colostrum. The child was then allowed to take the breast, and nothing further abnormal was observed. It should be mentioned that the woman was perfectly healthy, there were no traces of gout, haemorrhoids, cancer, or of haemorrhagic diaesthesia.—*Lancet.*

DOSE OF TINCTURE OF NUX VOMICA.

Mr. Jonathan Hutchinson (*Archives of Surgery*, January, 1890, p 280) says he has for many years prescribed the tincture of nux vomica very freely indeed. He thinks it the best of all tonics, for it very rarely disagrees, and he has never known it to produce poisonous effects. He generally gives 10 minims three times a

day to an adult, but often double that dose. He has given 5 minim doses to a child often, and has, for experiment, taken himself a single dose of 30 drops and realized no symptoms of strychnia poisoning whatever.

He believes the tincture of nux vomica to be a safer and more convenient form than any of the solutions of strychnia, and it has also the advantage of not exciting alarm in the patient. He says it may be taken for months together, and does not diminish in efficiency. Mr. Hutchinson has had many patients who have taken more than was intended and yet never so far with any serious ill result.

He relates two cases. A gentleman, 33 years old, took by mistake five consecutive doses of 40 minims three times a day instead of 10 minims during the same time as ordered. The only ill result was that the head had been made to feel dull and the eyes heavy, as if he had been drunk over-night. There was no muscular twitching.

In the second case the patient took 40 minim doses of the nux vomica tincture. He continued it three times a day for four doses in succession. The symptoms were exactly as in the other case—a dull feeling in the head, but no twitchings. He felt “wonderfully better for it.”—*American Druggist.*

THE TREATMENT OF ANAL FISTULA.

Dr. Guyon does not regard it necessary to operate in cases of anal fistula so long as the disease is tolerated by the patient. The non-operative treatment consists in the employment of scrupulous cleanliness of the parts and improvement of the general health by reconstructives such as the following mixture:

R	Potassii bromidi	10.0
	Potassii et ferri citratis	0.50
	Syrup. cortic. aurant.	
	amari.	100.0

Sig. One tablespoonful morning and night.

The stools should be kept soft, and for topical use the following suppositories are recommended:

R	Iodoform	0.10
	Extract belladonnæ	0.02

Sig. Introduced after each movement of the bowels, and on going to sleep.—*International Journal of Surgery.*

THE GASTRIC JUICE IN DIABETES.

In a long article on the condition of the gastric juice, saliva, and perspiration in diabetes, Dr. Ponomaroff details a number of observations which lead him to dispute the assertions of some previous observers—e. g., Heller and Frick, who believed that they had detected sugar in these secretions. With regard to the gastric juice, Dr. Ponomaroff points out that where this is obtained by making the patients vomit, what is obtained is not gastric juice alone, but an admixture of that with a certain quantity of bile. This generally contains sugar, and therefore vitiates the result. When the oesophageal tube is used and the gastric juice free from bile is obtained, there is, he states, never any sugar in it.—*Lancet*.

AN INJECTION FOR FISTULÆ

The following is recommended as of much service in promoting a cure of fistulous tracts:

R	Camphor	ʒ j
	Salol	ʒ ss.
	Ether	ʒ j

—*Medical Record.*

BACCELLI'S MIXTURE.

According to the *Deutsche med. Wochenschrift*, June 5, 1890, Mistura Baccelli, useful in malaria, has the following formula:

R	Quininæ sulphatis	gr. xlv
	Ferri et potassi tartratis	gr. cv
	Aquæ destillatæ	f ʒ x
	Liquoris potassi arsenitis gtt.	xxx

M. Sig. One to three tablespoonfuls daily.

If in severe cases other modes of absorption are not available, Baccelli makes intra venous injection of quinine:

R	Quininæ hydrochloratis	gr. xv
	Sodii chloridi	gr. xii
	Aquæ destillatæ	ʒ iij 3 ij

M.—

—*Med. and Surg. Reporter.*

Medical Items.

King Humbert, of Italy, is said to receive at least forty prescriptions for dyspepsia every week.

Dr. Friederich Arnold, the oldest German teacher of Anatomy and Physiology, died recently at the age of seventy-seven.

The Surgeon-General of the Army, Dr. John Moore, will be retired on August 16th, on account of his reaching the age limit.

It is reported that recently a New York baby fell five stories and landed unhurt, except for a little bump on its forehead and a slight sprain or one of its ankles.

In Egypt foundlings are placed in the charge of wet-nurses, who are inspected weekly and fined if either child or nurse is not well and in good condition. The plan is said to work well.

The American Dermatological Association will hold its Fourteenth Annual Meeting, at Richfield Springs, New York, September 2d, 3d, and 4th, 1890.

On account of ill health, Dr. H. E. Knipp of this city, will sell his horse, carriage, and practice, to a great advantage. For further particulars apply or write to 723 Scott street, Baltimore.

Philadelphia and New York physicians do not like strict Jersey justice, which will prevent them from practising in that State without passing an examination before a board.

By a recent decision in Harrisburg, Pa., the physicians of Pennsylvania who have practised three years under the law are entitled to registration as apothecaries without examination.

It is stated that the Commissioners of Charities of New York City have obtained possession of real estate near Bellevue Hospital which will increase the depth of the hospital 150 feet, an extension that has been greatly needed for some years.

Florence, Italy, is especially generous in medical charities. The Misericordia provides gratuitous nursing, food and care of children, and La Guardia gives medical attendance at all hours of the day or night, to all who are unable to pay.

Queen Margaret College, Glasgow, will open a fully-eqquipped medical school for women next October. At the University of Aberdeen, the General Council proposes to throw open every class to women, without restriction.

It is said that a retired physician of this city, who has recently committed an act apparently not honorable, was one of the strongest opposers of the defeated Medical Practice Act, and prevented the Governor from signing it. This seems to cast a reflection on our worthy Governor.

There are three floating hospitals in the North seas, designed to go from point to point among the deep-sea fishermen. The skippers of these vessels have been instructed to some extent in the principles of "first aid" in the accidents and ailments to which the fishermen are exposed.

The faculty of the Chicago Polyclinic

have made the following appointments. Dr. G. Fütterer (late chief assistant to Prof. Rindfleish of Würzburg), Dr. F. C. Hotz and E. Fletcher Ingals, Professor of Internal Medicine, Ophthalmology and Laryngology, respectively; also, Drs. Chas. F. Stillman, P. S. Hayes and J. M. Patton, Associate Professor of Orthopædic Surgery, Electro-Therapeutics and Medicine, respectively.

According to the *New York Tribune* it has been found that Walter Lethbridge, a clerk who has held a \$1,000 place in the Health Department for a year, has been utilizing the information he is able to get through his official capacity regarding the homes made happy by the births of infants by furnishing to manufacturers of baby foods, safety pins, soothing syrups, infant cordials, perambulators and improved clothing for children the names and addresses of the parents.

There is a child in Trenton, N. J., who has smoked tobacco since he was seven months of age. He is quoted as a remarkable instance of hereditary taint, and was weaned early by the proud mother in order that he might give full bent to his taste. A little daily counter-irritation in the shape of spanking might turn the thoughts of this youthful monster in another and better direction.

The French Temperance Society has received a gift of \$200 from Madame Lunier, to be offered as "The Lunier Prize" for the best essay on the following questions: "What are the consequences of hereditary alcoholism, and what are the best means of prevention, or means to limit or lessen its effects?" Authors are expected to follow out the lines of inquiry suggested in Lunier's work on alcoholism. All manuscripts should be received before December 31, 1890, and should be addressed, Dr. Motet, Secretary-General of the French Temperance Society, 161 rue de Charonne, Paris, France.

MARYLAND MEDICAL JOURNAL.

VOL. XXIII. No. 15.

BALTIMORE, AUG. 9, 1890.

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Original Articles.

THE APICAL TENDENCY OF PULMONARY CONSUMPTION.*

BY WILLIAM B. CANFIELD, A. M., M. D.,

Chief of Chest Clinic, University of Maryland.

In making a differential diagnosis between a beginning phthisis and other diseases of the lungs, the greatest stress is laid (and with justice, too) upon the upper part of the lungs. The different physical signs which we are accustomed to associate with phthisis are made principally significant by the fact that they occur, first at the apex of the lung. Now, why is the apex of the lung first affected and most affected in consumption? The many explanations vary and do not seem to be sufficiently satisfactory, and

although this paper may throw no additional light upon the subject, still a review of the opinions may not be amiss. In looking over the text-books and works on the subject, so far as they are accessible, it has been found that some give no reason for this, merely stating it as a fact, some give an explanation with an air of doubt, while others give these explanations with an air of certainty. Fagge points out that the upper part of the lung is more prone to be affected, whether the virus be disseminated through the respiratory tract or through the blood. This he does not attempt to explain. The most common reasons given are as follows:

1. Rindfleisch says as the apex is the highest part of the lung, it is the most anæmic.

2. Ziegler says the apex is so frequently already changed by non-specific processes, and is thus favorably predisposed or prepared for a tuberculous inflammation.

*Read before the Clinical Society of Maryland, April 15th, 1887.

3. The apex has little to do with the respiration and the air there is not often changed, for which reason inflammatory processes are apt to become chronic there, and the secretions are not easily carried away.

4. Dr. Hamilton thinks that the proclivity of the apex to phthisis is because it is the dryest part of the lung so that caseation of catarrhal products are more apt to take place there.

5. According to Freund in Ziemssen's Handbuch, the early ossification of the first costal cartilage prevents the apex from expanding sufficiently, and to prove this he quotes instances in which fracture of the first costal cartilage in tuberculous patients had caused improvement of the symptoms.

6. The apices are so frequently enfeebled by contractions of the upper part of the bony thorax, whether by want of muscular activity and development, or by round shoulders through carelessness and indolence, and from confining work at desk or trade.

7. The apex region in this enfeebled condition is soonest reached and most easily affected by the frequent recurring catarrhal inflammations descending from the larynx and trachea.

8. The apices when invaded by hyperæmia or catarrhal processes are not favorably affected by the force of cough. The closure of the glottis in cough detains and impacts catarrhal products in the tubes and vesicles of the apices, and renders them especially the seat of phthisis.

Doubtless time and labor will find many more explanations of this fact.

The theory of Dr. Arthur Hanau as expressed in a recent number of the *Zeitschrift für klinische Medicin* seems to explain more satisfactorily the actual fact, and at the same time to remove many of the reasons above given, and although his theory may be very faulty, still it seems to be clearer than any yet given, and I think, therefore, that the value of this paper lies in an exposition of this theory. Without attempting to

take up all these eight points, I shall simply quote Hanau's replies to the first three, and give his theory.

1. He considers the explanation of Rindfleisch that the apex is most anæmic, to be a very weak reason. We know that a badly nourished organ, poor in blood, is much less resistant against every attack than one well nourished, and we also know that a lung with congenital stenosis of the pulmonary artery is much more frequently the seat of phthisis, a thing which Klebs pointed out long ago. If we consider the slight differences in height between the trunk of the pulmonary artery and the apex, it is not easy to see why the pressure in this vessel can not overcome the slight resistance. Further this difference would only come into consideration when the patient was standing or sitting and finally, we often find an anæmic lung which is emphysematous, in which condition tuberculosis is very rare.

The second point might have had some support at a time when the opinion was that a tuberculous inflammation could start from any kind of inflammation. It might be that non-specific inflammation made a way for the tuberculous, but even this is hardly probable, for we know that the two most common forms of old changes in the lungs at the apex, the cirrhotic lung, from the inhalation of coal and metallic dust do not generally lead to bacillary phthisis. This last statement is contrary to the views of Nie Meyer, but is supported by Flint, Cornil and Ranzier, and others.

The third point carries the most weight with it, but even this reason seems to be traditional and without sufficient foundation. The first objection to it was the fact that Hanau found in the dead house a large number of cases of anthracosis and chalcosis, in which the most pigment was collected at the apex, while the remaining parts of the lungs were comparatively free from pigment, and often when there was no pigment at all at the lower part of the lung, the apex contained it,

and especially that part of the lung situated one-half to one inch below the apex, which is the favorite seat of tuberculous deposit. In the cases of emphysema which he examined, this condition of things was not found. He at once said that if the inspired dust found its way with more ease to the apex, it is obviously impossible that this part of the lung takes too little part in respiration; indeed it must, on the contrary, be in a condition to inspire more dust than the other part of the lung. He also could not understand how the bacilli got into that part of the lung which took such little part in breathing, and why the collapse of the lung never affected the apex, as long as the bronchi were open, while, on the contrary, in emphysema and volumen pulmonum auctum, the apex was by preference affected. From our knowledge of the tubercle bacilli, we may say that that part of the lung is most apt to be attacked then, into which they easily enter, and are with difficulty expelled, provided, of course, they find a suitable soil to promote their growth. At all events, those parts of the lungs not surrounded by bony walls, will distend more easily, and receive relatively more air, and air filled with foreign particles.

The conclusions from the foregoing, are that the apices take an active part in inspiration, and are therefore in an especially favorable condition to receive all dust and microorganisms mixed with it: They expire badly and hence, the inspired particles find the best opportunities to remain where they are, or by retrograde current of air to be driven still further into the lung.

1010 North Charles Street, Baltimore.

Dr. G. E. Fenwick has resigned the chair of surgery at the McGill University, Montreal, owing to impaired health. Dr. T. G. Roddick, one of the editors of the *Montreal Medical Journal*, will be Dr. Fenwick's successor.

PHYSICAL EDUCATION IN RELATION TO MENTAL DEVELOPMENT IN SCHOOL-LIFE.*

BY THOMAS MORE MADDEN, M. D.,
F. R. C. S. ED.

Physician to the Hospital for Sick Children, Dublin; Obstetric Physician and Gynæcologist Mater Misericordiae Hospital; Examiner Conjoint Board Royal College of Surgeons and Apothecaries' Hall, Ireland; Consultant National Lying-In Hospital; Ex-President Obstetric Sections of the Royal Academy of Medicine, Ireland, and of the British Medical Association; Formerly Vice-President British Gynæcological Society; M. D. *Honoris Causa* Texas Medical College, etc.

The respective claims of physical and mental training, and the evils arising from the neglect or abuse of either are obviously questions of the highest medical as well as social interest. This neglect now presents itself in two different aspects.—On the one hand, the children of the poor in England are completely subjected at an absurdly early age to a forcing and injurious system of mental cultivation. Whilst on the other hand, in the case of those of a better social position, the physical powers are not uncommonly overtrained, at the expense of the mental faculties. Of these errors, the former is the most important, and to its operation is, I believe, largely ascribable the apparent diminution of physical stamina observable in too many of the youth of the present day as compared with the physically more robust, if intellectually less cultured generation of the pre-educational period. Looking at the overtired and anaemic little children now chained to the desk by the School Boards, we might be tempted to believe “Twas not the sires of such as these Who dared the elements and pathless seas; But beings of another mould— Rough, hardy, vigorous, manly, bold!”

*Abstract of a Paper for Section Diseases of Children.—British Medical Association, Birmingham, July, 1890.

At the present time, a large part of the first ten years of life, which should be primarily devoted to physical and moral training, is given up to the development of the mental powers; the child when a mere infant, being compelled to attend some school, where the immature brain is forced into abnormal and disastrous activity. On its return home, jaded in mind and body, to prepare for next day's task, such a child is necessarily unfit for the enjoyment of the physical exercise which is essential for its bodily development and health, or for the still more important elementary training of the affections and moral faculties and instillments of religious principles, which are better acquirable from home teachings than from any School Board system. We are all of course agreed as to the duty of properly educating children so as to fit them mentally and bodily for the increasing requirements and competition of modern life. But as to the extent to which the former should be carried and the latter neglected in early childhood, there is unfortunately a great discrepancy between the rulers of the Education Department and the views of those who have to deal in disease with the consequences of the violation of the laws of nature. And hence, whilst little children are thereby overworked into disease or death, the physician must still raise his protesting voice, albeit it would apparently seem unheeded.

During the first eight or ten years of child-life, the amount of mental cultivation which a child's brain is capable of receiving with permanent advantage is much less than is commonly believed. No greater physiological mistake is possible than that of attempting any considerable degree of such culture until the sufficient development of the physical stamina and moral faculties is accomplished. The organ of the mind is as much a part of the body as the hand, and ere either can function properly, its vital force must be fostered and maintained by nutrition and developed by physical exercise. A large proportion of

those who come within the provisions of the Elementary Education code are semi-starved children of the poorest class who, when thus debilitated by privation, are necessarily as much incapacitated for any mental strain as for the accomplishment of any herculean feat of physical strength: it being not less inhuman, injudicious, and impolitic to expect the former than it would be the latter from those so circumstanced.

If the State, for reasons of public policy, determines that all children shall be compulsorily educated from their earliest years, it should certainly afford the means by which this may be least injuriously and most effectually carried out, by providing food and physical training as well as mental education for every pauper child attending an Elementary school.

Amongst the results of overpressure in such schools under the Boards referred to are brain disease in all forms—viz., cephalitis, cerebritis, and meningitis, as well as headache, sleeplessness, neuroses of every kind, and other evidences of cerebro-nervous disorders. On no other ground can the increasing prevalence of these affections amongst the little victims of the Educational Department be accounted for or explained, than by ascribing them to the new factors "brain excitement" and "overpressure," which in the case of young children are now too commonly disastrously associated with the process of mis-directed education and neglected physical training.

In connection with the physical management of childhood, I may add a few words on the abuse of alcoholic stimulants. The evils resulting from the abuse of alcohol were never so prevalent as at present, and are traceable in the diseases of youth as well as in those of adult existence. The results of this acquired or inherited alcoholism are brought under clinical observation in the form of cerebral gastric and hepatic disorders, and especially cirrhosis of the liver, which as well as the protean forms of cerebro-spinal disease, and the various neuroses so frequently noticed in hospi-

tals for children, and to which I have elsewhere directed attention. In the majority of these cases of juvenile alcoholism that have come under my care in the Children's Hospital Dublin, this tendency appears inherited and most marked in those whose mothers were inebriates—intemperance in women also bearing in other ways on the diseases treated in hospitals for children, where its effects are strikingly evinced by the moral and physical deterioration of the offspring of the drunken and by their special predisposition to strumous, tubercular, and other constitutional taints.

Under no circumstances should alcoholic stimulants be given to children, save in the guise and defined doses of other remedial agents—my experience in hospital and private practice, at home and abroad, having amply confirmed the view expressed in a work of mine published many years since, viz., that it is physiologically wrong, as well as morally unjustifiable, ever to allow a healthy child to taste alcohol in any form.

CONSTIPATION: ITS RELATION TO SYMPTOMS OF UTERINE DISEASE.*

BY CHAS. B. ZIEGLER, M. D.,
OF BALTIMORE.

A few weeks ago a lady called at my office complaining of pain in the back, in the groins and down the thighs, and of a feeling of weight in the pelvic region. She supposed that the pain and discomfort was due to some uterine disease. In answer to a question in regard to the condition of her bowels, she replied that she was regular. "How often do you go to stool?" I further inquired. My patient hesitated, and then with a blush answered, "Once a week." It is perhaps needless to say that a laxative taken daily has effected a cure.

I am sure that cases similar to the above are not unusual with you. How often we are called upon to prescribe for headaches, pain in the back, spells of dizziness, and dyspeptic symptoms, due to a torpid condition of the bowels, and as often fail to impress upon the patient the true cause of their discomfort, and in consequence fail to cure.

Few women recognize the importance to the general well-being, of a free daily evacuation of the bowels. From seven out of ten women we find, "Once or twice a week is as often as I go to stool," a stereotyped answer to the question of "How are your bowels?" And this from women who are apparently hearty and robust, with good appetites, but who come to us complaining of headache, pains in the back, and perhaps spells of dizziness.

Some few years ago, I was called to see an old lady who wanted me to do something for her dizzy spells. I found that she was habitually constipated. When I told her that I thought the bowels were at fault, and should be emptied daily, she became somewhat provoked with me. "Why," said she, "I do not think my bowels have anything to do with them. I have not had a passage more than once a month since I was a child." She continued to suffer from her "dizzy spells" until an attack of rheumatism put her into bed and at my mercy. I then saw to it that she did have more than one passage a month, and the last time I heard from her, she was free from her dizzy spells. Her daughter has told me that the monthly evacuation resembled a short labor.

The relation of constipation to symptoms of uterine disease, is well exemplified in the following cases. When I speak of symptoms of uterine disease, I am well aware of the fact that there is no group of subjective symptoms that can be relied upon alone, as positive evidence of the ordinary diseases of this organ. Therefore I mean those symptoms which, when sufficiently aggravated, lead us to advise an examination *per vaginam*. The

*Read before the Medical and Surgical Society of Baltimore, June 12th, 1890

relation of the following cases, will probably be sufficient to show how often pain in the pelvic region is due as much to constipation as to uterine disease.

Miss N., white, aged 20 years, came to my office about a year ago. She complained of great pain in the right side, in the back, and down the thighs. She gave the following history: First menstruation occurred when she was thirteen years of age.

Has always been regular since. Amount of flow not large. Duration four days. Had no more than the usual discomfort, until four years before I first saw her. At that time she began to suffer at intervals, to a slight degree, of the pains I have already alluded to. There was also more discomfort at the menstrual periods, but the pains were not confined to these, nor did they recur at every period. She has been having for the last two years, fainting spells. The pains have increased in severity, and the faintings have become more frequent, until now she is scarcely ever without pain, and the faintings are of common occurrence. She has slight leucorrhœa and is constipated. This patient being a young unmarried woman, I did not ask that an examination *per vaginam* be allowed, but I told her that I suspected something was wrong with her womb. I advised a blister on the right side, over the seat of pain, and prescribed a laxative, charging her to use it so as to secure a daily stool.

I told her that if she was not relieved an examination might become necessary. Six months later she came again to see me. She complained that she was worse than ever. Pains and faintings had both increased in severity and frequency. I now suggested and urged the advisability of a vaginal examination. It was reluctantly allowed. When I succeeded in introducing my finger into the vagina, I found the whole pelvic cavity filled with a mass of something. At first I was at a loss to discover what it was. It was more like the mass of inflammatory deposit found in a severe pelvic cellulitis, than anything else that I knew of. I

found the uterus in a latero-flexed condition, crowded well to the right and forward, but the organ itself was healthy. The mass I found to be feces. I then questioned her closely as to when she last had a movement of the bowels, and she answered a few days before. This did not appear to me to be consistent with the condition of things, and I asked her if she was sure of it. She then remembered that the last evacuation was upon a certain day. Counting back to this date we found ten days had elapsed. She at first refused to believe that so long a time had elapsed, but as she was positive of the date, she was finally convinced. I told her that I thought the constipation was the whole cause of her trouble, and that proper attention to her bowels would relieve her eventually of her pain. She has followed my advice and a cure has been the result.

A second case was that of Mrs. W., white, aged 33 years, the mother of four children. She came to me complaining of pain in the back, in the lower part of the abdomen, especially on the right side, and headache, bowels constipated. I ordered a laxative so as to secure a free daily evacuation of the bowels. Entire relief was obtained.

Another case was that of Mrs. L., colored, aged 24 years, complained of pains in the back, in the iliac region, more severe on the right side and down the thighs. Upon examination I found slight vaginal and uterine leucorrhœa. The rectum was loaded with fecal matter, and the uterus pushed forward and to the right. I ordered her to see to it, that her bowels were freely moved, and directed her not to allow herself to become constive again. A cure was the result. About six months later she came to me again complaining in the same way. The same treatment secured the same result.

A fourth case was that of Miss H., white, aged 23 years. Had been suffering for two years from severe cramp-like pain in the right side, pain in the back, feeling of weight in the pelvic region,

locomotion sometimes painful, she is constipated. I examined her, as she had come to me especially for examination, but found nothing to account for her symptoms except constipation. Attention to the bowels in this case, as in the others, secured relief.

These four cases are sufficient, I think, to show what a great factor constipation is, in the production of symptoms, that are usually taken to indicate some uterine disease. I would also call your attention to the persistent recurrence in this history of these cases of one symptom, that of pain in the right side. I think this is probably due to the displacement of the uterus forward and to the right, thus taking up the space in the right half of the pelvic cavity and crowding the ovary.

As to treatment, little need be said. One thing, however, is necessary, to impress your patient with the importance of daily emptying her bowels.

920 North Broadway

DERMOID CYST OF OVARY, TWISTED PEDICLE. RECOVERY.*

BY DANIEL T. NELSON, M. D.,
OF CHICAGO, ILL.

The contents of this tumor were entirely of a kind of wheel-grease, sebaceous matter. There was about a gallon of it. It has kept very perfectly without any preparation except being bottled. There were a few short hairs, but no teeth or bones.

I will read you a brief history of the patient.

Mrs. G. B. R. Puberty at 14; aged 57; married thirty-six years; two children, 33 and 29 years, both girls; first weighed nine pounds, second six; was in bed at each confinement ten days; nursed both children. Has had three attacks of pneumonia, first while a girl before marriage; ill five or six months; second in 1864; ill

a month; third 1880, ten days in bed. During convalescence, while sitting up, suddenly expectorated some four or five ounces of pus and then rapidly recovered; but has since had a cough on rising from bed in the morning and on lying down. In June, 1888, had a slight attack of peritonitis lasting some three days; hardly in bed. Suffered from soreness for some days after. A second attack of peritonitis occurred in October, 1888; was in bed a week, soreness continuing for a week or more longer. The third and last attack of peritonitis began May 23d, 1889, and was produced by stooping in her garden to pick some lettuce. She took to bed that night and was obliged to remain a month. She suffered greatly for some days, and for a time her life was endangered. Was confined to her house two months. During all of these attacks of peritonitis bowels were never confined for many days, and at other times were regular or easily moved by simple laxatives.

The patient came for operation on the tumor, which was recognized months before, on the 30th of November. The patient was of a decidedly corpulent build. The usual abdominal incision was made; some three inches of adipose tissue had to be passed through before the abdominal cavity was reached. The tumor was found adherent to the whole anterior peritoneal surface, but the adhesions were apparently of recent date. The abdominal incision was made some ten inches in length, the whole size of the tumor. This was necessary in order to pass the hand around the tumor to free it from its adhesions. This was done without causing severe hemorrhage or injuring any of the viscera. After the tumor was freed from its adhesions it was opened by the trocar, but there was no discharge of fluid, which was easily explained on the withdrawal of the trocar, when this sebaceous material began to well out; the opening was enlarged and gradually the whole contents of the tumor were evacuated without any of it passing into the abdominal cavity.

*Read before the Gynaecological Society of Chicago.

When I was able to see the pedicle it was tied and cut off. It is just about the size of an ordinary lead pencil, and was twisted three times around, three complete revolutions of the pedicle. The pedicle was afterward tied a second time and cut off, so I have this part to show you to illustrate its size. On account of the adhesions I was not able to satisfactorily locate the origin of the tumor. I believe it represented fully and completely the left ovary; it was all I could find of that ovary. The left Fallopian tube was adherent to the exudate about the tumor; the right ovary and tube were also inflamed and adherent, but could be found, but I could not find the left ovary. Of course I did not make as careful a dissection as if it had been a post-mortem case. But the condition of the pedicle was an astonishment to me; it did not seem that any blood could pass through the original vessels of the tumor. The tumor had not sloughed, as it seemed to me, simply from the new vessels it had acquired from adhesions the result of recent inflammation. It is possible, of course, that there was some blood supply in other ways, but it seemed as if no blood could pass through the natural pedicle. After the last attack of peritonitis the statement of the friends was that she had seemed to grow considerably smaller in size. Whether it was because the peritoneal effusion was completely absorbed with the fluid portion of the cyst or not there was absolutely no fluid with the sebaceous material at the operation.

The after-treatment was exceedingly simple; a glass drainage tube was introduced, which was subsequently removed and replaced by a short rubber tube. The extreme temperature of the patient reached $100\frac{1}{2}$. A troublesome cystitis was induced by the use of the catheter, and lasted about a week. This gave the patient more annoyance than anything else about the operation.

I have seen two cases of twisted pedicle, one in the case of a solid tumor which was removed post-mortem. There was twisting of the pedicle and a peritonitis

that so endangered the life of the patient that I did not dare operate, but the post-mortem showed that her life might probably have been saved if operation had been attempted.

The instruction to me is that a peritonitis coming on after exertion in a patient with a movable tumor indicates twisting of the pedicle, and, if the case is grave, operate before the peritonitis kills the patient. If the attack is slight it may be well to wait until the peritonitis has passed by; yet it would seem from the treble twisting in this case that waiting was dangerous, the third attack of peritonitis being much the most severe, and the third twist of the pedicle almost cutting off the blood supply; there was grave danger of the complete death of the tumor. If the peritonitis endangers the life of the patient, operation should be proceeded with at once.

Society Reports.

CLINICAL SOCIETY OF MARYLAND.

STATED MEETING HELD APRIL 18TH, 1890.

The 233rd, meeting of the Clinical Society of Maryland was called to order by the Vice-President, Dr. W. H. Norris, in the chair.

Dr. W. B. Platt read a paper on

TWO CASES OF TUBERCULOUS OSTEO-MYELITIS,

operation and exhibition of patients.

Dr. Randolph Winslow said that he did not think that muscular attachments were of much importance in considering resections of bones: that there may have been no sinuses remaining in this case if more bone had been removed seems possible. If necessary muscles can be re-planted.

Dr. John W. Chambers said that when the bones of extremities are so diseased

the amount of bone removed is not of much importance. An enormous amount of bone removed is better than amputation. He himself has taken away $\frac{3}{4}$ of the femur with the result of a dangling useless limb. He dreads long continued suppuration, fearing that it will cause amyloid changes in the kidneys, &c. He does not regard an operation as being complete when any dead bone is left behind.

Dr. Walter B. Platt said in his case the bone seemed sound except in one place. The patient was in no condition to undergo a more extensive operation. Sometimes patients do well even though a sinus is present for some time. They sometimes finally heal. A small focus of tuberculosis in bone is not so dangerous as when in the lungs or other internal organs.

Dr. R. B. Norment reported two cases of

BLADDER TROUBLE,

one simulating miscarriage and the other labor. Both occurring in pregnant women, and both in his experience were unique. In one the diagnosis was cystocele and the other vesical haemorrhage.

Dr. A. C. Abbott read a paper on

BACTERIA IN WATER.

In the paper he discussed the part taken by drinking water as conveying the germs of cholera, typhoid fever, &c. He discussed the life history of pathogenic organisms, cited various epidemics undoubtedly depending on water infection and described various remedies to be applied to the water supplies of different cities in rendering them fit for use. Of the filters in use the sand filter is among the best, the bacteria forming a filter themselves against other bacteria. He discountenanced the use of household filters except, perhaps, that of Chamberland.

Dr. R. L. Randolph asked as to the possibility of limiting distance of infec-

tion as conveyed by water. Could it come a distance of fifty miles?

Dr. L. E. Neale asked as to the influence of heat and cold on water.

Dr. J. T. Smith thought it would be of much practical use to render drinking water pure, without going through the process of filtration.

Dr. George H. Rohé spoke of the considerable amount of work that has been done in the United States in reference to water, contagion, and cited the observations of Dr. Van de Warker of Syracuse New York, going to prove the theory of drinking water contagion in typhoid fever. He thinks, for typhoid fever and cholera, the theory prevails. He thinks that the two theories can be harmonized, thus in the process of drying out ground water, drinking water becomes contaminated, approaching the drinking water theory: that stream purification depends on the length of the flow, the position, etc. Many organisms live out their lives, the stream becoming pure further down. The tendency now is to keep the water pure from the beginning, and physicians are doing more in that direction than formerly. A good method for disinfection of typhoid stools is to add to it twice its volume of boiling water.

Dr. A. C. Abbott said in conclusion, that we must always consider the size and velocity of streams, and that a stream will first regain its purity at about thirty miles from town. Cold plays no part, but boiling water absolutely frees it from germs. As a method of disinfecting stools, he cited the recent work of Foard, of Berlin, who adds to the stool enough of the milk of lime to render it alkaline.

W. J. JONES, M. D., *Sec'y,*
1238 Greenmount Ave.

There is a law in Bulgaria to the effect that if a patent medicine, which is advertised to cure a certain malady, fails to do so, the vender of the remedy is liable for damages, and may also be sent to prison for a limited period of some time as a punishment for publishing an untruth to the injury of the public.

MARYLAND MEDICAL JOURNAL

Weekly Journal of Medicine and Surgery.

WILLIAM B. CANFIELD, A.M., M.D., Editor

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BALTIMORE, AUGUST 9, 1890.

Editorial.**A MUSICAL INSTRUMENT IN THE BRONCHUS.**

The removal from the trachea and large bronchi by tracheotomy of objects which have been accidentally swallowed and have slipped past the glottis is at present not a very rare operation.

In the *Medico-Chirurgical Transactions* (London) vol 72, 1889, p. 444, a case of this sort related by Dr. Bryant which is, from the nature of the obstruction, unusually interesting.

A boy, 7 years old, while playing with a toy trumpet, swallowed and drew into his windpipe the mouth-piece which contained the musical works. The accident did not produce any special distur-

bance, except momentary cough. A physician examined him with the laryngoscope but found nothing amiss. The patient then started for London, for treatment in Guy's Hospital, and, while on the train, amused himself and the passengers by tooting on his invisible whistle, which was evidently lodged somewhere in his air passages. When he coughed or expired forcibly the note of the instrument was distinctly heard. When seen, about 3 hours after the accident he was breathing naturally and exhibited no symptoms of constitutional disturbance. The chest signs were normal, and no rales of obstruction could be heard when the lungs were auscultated. As the patient could cause a whistle when the mouth was closed and the nose open, but failed when the nose was closed and the mouth open, the instrument was supposed to be in the posterior nasal cavity, but examination failed to reveal it.

He was left quiet in bed. On the 8th day he lost power to blow the whistle, the temperature being still normal and no cough nor chest symptoms being present. On the 12th day cough appeared and it was seen that air did not enter the left lung as well as it did the right. There were no signs of pneumonia, but it was decided that the instrument was in the left bronchus. Next day, after chloroform administration and tracheotomy, the body of the child was tilted with feet up and shaken forcibly, and, this failing, the trachea and bronchi with their branches were sounded with a long silver probe. After repeated attempts, the probe struck something in the left chest which sounded like a foreign body. Passing a forceps down $5\frac{1}{2}$ inches below the tracheal wound, Dr. Bryant seized and removed the tin whistle, which was

about an inch in length and lay with the small end downwards.

The patient recovered rapidly from the operation, and left the hospital well a month after it was performed. The case is worthy of note because of the difficulty of diagnosis, the slightness of the inconvenience caused by the hollow foreign body, and the successful removal of the instrument after such a lapse of time. Why the whistle could not be sounded when the nose was closed and the mouth open, is not known.

A NEW METHOD OF TREATING SYPHILIS.

Before the French Society of Dermatology and Syphiliography, Dr. Quintaud has made a communication on the above subject. Struck with the fact that certain diseases could not, or would not recover under the usual treatment, he thought out a new method of treatment. In the case of syphilis, his idea was to give certain insoluble remedies, as calomel, and here is his formula:

R	Emplastrum diachylon	3,000 gr.
	Calomel	1,000 gr.
	Ol. Ricini	300 gr.,

This is applied on a plaster over the splenic region for eight days and then it is applied on another region for eight days more. The theory is, that infinitely small quantities of mercury are absorbed by the skin and the system is continually under its influence during the eight days. Cases are shown to do well under this treatment.

Correspondence.

LONDON LETTER.

DESCRIPTION OF SAINT BARTHOLOMEW'S HOSPITAL—THE OPERATING ROOM—MANNER OF GIVING ANÆSTHETICS IN OPERATIONS ON THE UPPER AIR-PASSAGES—THE OPERATION.

LONDON, July 16, 1890.

Editor Maryland Medical Journal:

DEAR SIR:—While travelling around and studying at the different foreign hospitals and universities, I thought a letter, written from time to time for your JOURNAL, might interest your readers. Just now I am spending some time "walking" St. Bartholomew's Hospital, and have been so pleased with it that I want others to learn something about it too.

St. Bartholomew's Hospital is pleasantly situated in the East Central portion of London, and in one of the oldest and most richly endowed hospitals in London, having a yearly income of £40,000 (\$200,000.) This hospital was founded in 1123, by Rahere in the reign of King Henry I, with whom the founder was a great favorite. St. Bartholomew's Hospital contains 676 beds and treats as many as 6000 indoor patients yearly, while the out-patients amount to 140,000 annually.

The present quadrangular edifice was erected in 1730, and has two main entrances, within the area of the hospital is found a pleasant retreat for convalescing patients with shade trees and walks. It was my pleasant privilege to see the attending surgeon operate one day early in June, and I now take pleasure in calling attention to some methods I saw in use there, notably the administration of chloroform and of its continuation during the operation in, or upon any part of the upper respiratory tract. Many of

our surgeons deem it advisable to perform tracheotomy when operating upon the upper air-passages or any of its appendages, but here is a means of keeping the patient under anæsthesia without performing tracheotomy, or in the least hindering the operator, by placing the cone with the anæsthetic over the mouth and nose of the patient necessarily stopping the operation until complete anæsthesia is again accomplished. A word or two as to the operating room and its arrangements. The conventional and useful amphitheatre is used, the seats are high and extend three-quarters around the room, the ceiling is made of glass, mostly to afford all the light possible, the table is in the centre of the room and smaller tables are here and there in the arena. An iron railing extends around the arena as far as the seats extend, thus separating the arena from the rest of the room. Entrance to the seats is gained by stairs from the back, while entrance to the arena is from another direction and under the tiers of seats, and this is the only way of entering the arena. It is hardly necessary for me to state that only those engaged in the operation are ever allowed to come within the arena, and those engaged are as few as possible. As soon as one enters the "theatre" you see that asepsis is the means of fighting "obes" and "ites" and "bacilli" and "cocci" and hosts of unnamed enemies, and not by allowing them to accumulate and then kill them with bichloride of mercury and other germicides. Everything is scrupulously clean and carbolic acid is the only agent used which is really not a germicide, as it in reality stimulates rather than retards the activity of germs.

Our patient is now brought in upon a wheeled table by the hospital attendants, and placed upon the operating table, his legs are strapped down to the table by a broad padded strap, and two assistants hold his arms. The "chloroformer" now proceeds to give the anæsthetic. This is done in the following way: He cuts a piece of absorbent lint, perhaps twelve inches long by about six wide,

then folds it crosswise in two, making a double piece six by six, having done this, he sees that his patient is properly fixed, etc. Laying the absorbent lint on the patient's face, he then throws on the top a few drops of chloroform and quickly reverses it, drawing it at the same time into a conical shape facilitating the more ready admixture of air, and as the amount of chloroform is small, the proper proportion is, I think, more readily obtained. He then again dashes upon the upper surface of the lint five or six more drops of the anæsthetic, and quickly reverses the cloth, bringing the wetted surface underneath, and draws the lint into the conical shape. The chloroformer repeats this several times, and gradually, without any violent movements on the part of the patient, the latter passes under the influence of the anæsthetic.

While our man is being anæsthetized let us learn the character of the operation to be performed, from the words of the operator. He tells us that his patient is 64 years old and has for some time past had a hardening of the anterior portion of his tongue which lately has protruded through the surface epithelium of the tongue, and supplicated somewhat. His diagnosis is clearly epitheliomatous growth of the tongue in its anterior portion, his treatment is as clear, but his prognosis is modified considerably by the age of the patient, the seat of the growth and duration; however there is a chance in an operation of recovery, and sure death if allowed to remain, so he has decided to operate.

By this time the patient is fully under the anæsthetic and the lint is now removed from the patient's face and the operation begins.

The attendants all have on gowns, but this is an aseptic, and not an antiseptic, precaution. The instruments are in a solution of carbolic acid and close to the operator.

Let us look to the chloroformer now and see how he keeps up the anæsthetic without interfering with the operator or stopping the operation.

Hanging from the gown of the chloro-

former we observe a small phial, holding, perhaps two ounces, and this is half full of chloroform. The bottle has a rubber cork with two openings, through which two metallic tubes pass; one tube is short, and only passes through the stopper, and then ends in the cavity of the glass vessel; the other, however, passes all the way down and nearly touches the bottom, being half submerged in the chloroform. Attached to this first tube—*i. e.*, the short one—is a long soft rubber tube, and to the end of this a hard rubber tube, such as that used for catheters and bougies; from the longer metallic tube in the bottle passes another soft rubber tube; to this is attached two rubber balls, as those used for a thermo cautery; the one nearer the bottle is soft and distensible and covered by means of a silk netting, to prevent over-distension, while the other is made of rubber that is thicker and slightly harder, provided at the end with a valve that allows air to enter, but prevents its escape the way it comes in, but must go on into the second ball and cause a distension of that. Thus, when the elastic and distended ball has been filled, it keeps up a constant and equable pressure upon the contained air, and this causes a steady flow of air through the chloroform, which air escapes through the second tube of the phial and passes on through the hardened rubber tube and escapes as air filled with a certain amount of chloroform. You can readily see that air passed thus through chloroform would be suitable for anaesthetic purposes.

The entire apparatus is hung from the breast of the gown, and the chloroform can easily be manipulated. The hardened tube, that from the phial, is bent at a right angle previously, and is now inserted into the mouth of the patient and back into the posterior portion of the pharynx. A few squeezes of the end rubber bulb distends the second elastic ball, and this in turn keeps up a steady and continuous flow through the chloroform. Of course it must be used judiciously, but does not the administration of an anaesthetic re-

quire judgment and care in any case? This form of continuing the anaesthesia has many advantages, among which are these, *imprimis*, it presents the inspired air to the pharynx in a proper, or nearly so, condition, *i. e.*, with the proper amount of chloroform vapour for anaesthesia, secondly, it administers it in a way that does not interfere with the operator or impede the progress of the operation, thirdly, it lessens the chances of any ill effects either from the chloroform itself or the mechanical obstructions that follow when the blood is flowing and the face covered with the cone used in many cases, the former way, allowing the mouth and posterior pharyngeal cavity to be cleansed by means of sponges or such like upon the ends of clamped forceps. The operation was a very pretty one, and I could not but admire the way in which the patient was saved all unnecessary wakings which are always distressing to witnesses, not to say annoyance that it causes the operator. During the entire operation the patient never evinced the slightest tendency to emerge from under the influence of the anaesthetic.

The operator began the operation by making two silk loops, one through each side of the tongue, so as to have complete control of that organ and prevent it from receding into the pharynx and thus cause mechanical obstruction to respiration. Having perfect control, by means of these two threads through the tongue, he then made a longitudinal incision in the median raphé of the tongue, and cut away laterally afterwards all epitheliomatous tissue. The operation was tedious on account of the parenchymatous and capillary haemorrhage, but this was stopped by means of pressure, which could not be used to its best advantage as there really was no hard substance to press the tongue against directly.

There may be some of my readers that would like to make a trial of this means of administering and continuing an anaesthetic, and it is in this belief that I send this letter across the water. Seeing

the immense comfort that the operator experiences from this method, I hope others in this country may adopt it and be benefited likewise. There can be no doubt that many objections can be urged against the use of the "cone" in giving chloroform, and many have been the modifications of methods in giving anæsthetics, and in them all I think that too large a percentage of chloroform vapour is administered, but by this method I think it almost an impossibility to give it in too large a proportion. This method, of course, applies only to chloroform and is in no way applicable to etherization as in the latter case, it is necessary to administer ether in as concentrated a vapour as possible, and with as little admixture of air as possible.

I am sure this is an excellent method of administering and continuing the administration of chloroform, and would be delighted to hear of any successful results of trials by any surgeons.

After leaving England, I expect to spend next winter on the continent, principally at Berlin and Vienna of course, and if my present good intentions do not desert me, I shall give myself the pleasure of sending you a few lines again.

Yours Very Truly,

ARTHUR D. MANSFIELD, M. D.

Reviews, Books and Pamphlets.

Practical Sanitary and Economic Cooking adapted to Persons of Moderate and Small Means. By MRS. MARY HINMAN ABEL. The Lomb Prize Essay. Published by the American Public Health Association, 1890. Pp. xi-190. Price 40 cents.

Any one who reads this well-written little book, will readily believe the saying that a Frenchman can live on what an American wastes. Mrs. Abel shows here

how to cook the most nourishing food in a palatable manner, and at a low cost. Of course some of the bills of fare sound rather unpalatable to the frequenter of Delmonico's and Rennert's, but the food has been proven sufficient by experience. The one great difficulty which it will be always hard to overcome, is to impress on the "persons of moderate and small means" the advantages of economic living. The workingman of all others is wasteful in his housekeeping, and often partakes of food that fills, but does not nourish. Practical and free lectures with demonstrations on the above subject would do much more good than the distribution of a book that the persons for whom it is intended will hardly notice. It is a mistake not to have the title of the essay on the cover.

Ueber Feuerbestattung. Vortrag gehalten am Abende des 13 Februars, 1890, in Verbindung mit Experimenten und unter Vorweisung von kolorierten Bildern im Naturwissenschaftlichen Vereine zu Mülhausen im Elsasse. Nebst Anhang und mit fünf Abbildungen im Texte, von Prof. Dr. Friedrich Goppleröder. Druck und Verlag von Wenz & Peters, Mülhausen i. Els. 1890. Pp. 108.

This is a very long and full address on cremation from a scientific and practical point of view. The author appears to have had no access to publications in English on this subject.

Twenty Consecutive Cases of Abdominal Section. By L. S. McMURTRY, A. M., M. D., of Louisville, Ky. Reprinted from the *Transactions of the Southern Surgical and Gynaecological Association*, November, 1889.

A Successful Case of Nephrectomy. By GEORGE BEN. JOHNSTON, M. D., Richmond, Va. Reprinted from *Virginia Medical Monthly*, July, 1890.

Varicocele. By THOMAS W. KAY, M. D.,

Scranton, Pa. Reprinted from the *Cleveland Medical Gazette*, December, 1890.

Charles Marchand has issued a pamphlet giving the therapeutic applications of peroxide of hydrogen and glycozone in the treatment of diseases caused by bacteria. Peroxide of hydrogen has been pronounced by Dr. E. R. Squibb to be the most powerful of all antiseptics and disinfectants. Its harmless character and the absence of all unpleasant taste and odor render it an ideal germicide for use with children.

It appears to us that this substance deserves a much more general trial than it has yet received; and to those who desire to know more of it we commend the pamphlet before us, which may be procured on application to Mr. Marchand.

Miscellany.

REPORT OF THE "MORGUE COMMITTEE."

Dr. George H. Rohé, commissioner of health, and J. Theodore Oster, inspector of buildings, who have been inspecting the morgue buildings in the cities of Philadelphia, New York, Brooklyn and Boston, have returned and submitted to the Mayor an exhaustive report of their tour, in which they explain the construction of the buildings, the manner of receiving dead bodies, their preservation and identification, and the final disposition of all human remains received.

The morgue in New York City, they say, is simply a large dead-house, where all the unknown dead of the metropolis are brought, whether found drowned, picked up in the streets or dying in the hospitals. No methods of preservation are carried out beyond covering the body with ice. The system of aids for the identification of the unknown dead is very complete and efficient. There is no public exposure of the bodies, but each is accurately described under a serial

number. A photograph is taken and numbered and the clothing and effects, after being described, are packed and stowed away and kept for six months. The grave is also numbered, so that the remains can be easily found in case they should be claimed by relatives or friends.

The morgue in Brooklyn is the largest and most complete of any visited. It is located near the business centre of the city and is about half a mile from the water front. It is used for the reception of bodies found drowned or picked up in the street and not immediately recognized. Sixty-seven per cent. of those received last year were identified.

The building originally contained a public show room, with a glass front, in which were stone tables for the bodies, but this has been abandoned because it was found impracticable to preserve the bodies, and it was useless for identification.

The bodies when received are covered with ice. The building contains an office, an exposing room, a preservation room, a jury room and quarters for the keeper. The methods of identification used in this morgue are not as complete as those in use in New York.

The Philadelphia morgue is similar in construction and management to that of Brooklyn. The public exposing room which was formally in use there has been abandoned. Two-thirds of the bodies received are identified.

The Boston morgue was originally constructed on the same plan as those in Philadelphia and Brooklyn, but there, as in the other two cities, the public exposition of the bodies has been found valueless and has been abandoned.

The autopsy room in this morgue is better than in any of the others, as the medico-legal examiner combines in his office the functions of coroner, coroner's jury and post-mortem examiner.

In Brooklyn the Baltimore officials examined the mortuary chamber attached to St. Catharine's Hospital, conducted by the sisters of St. Dominic. Here they found in use an excellent method of pre-

serving dead bodies by cold air. They believe this can be incorporated into the plans which they shall submit to the Mayor as soon as the details can be worked out. They think also that a morgue can be built which will combine all the best features of those which they have visited, without exceeding the amount appropriated, and that their visit will result in a saving to the city, as many expensive errors of other cities will be avoided.

The report concludes by expressing the obligation of the party to the officials of the cities visited who received them with much courtesy.

THE PHAGOCYTE THEORY OF METSCHNIKOFF.

The results of Metschnikoff's latest experiments constitute a valuable contribution to the interesting subject of immunity. To form a clear conception of the attitude of scientific opinion toward this theory it must be borne in mind that the resistance of the invaded organism to the invading micro-organisms is variously explained, now from the physico-chemical point of view, now from that of cellular biology. According to Baumgarten, a low temperature renders cold-blooded animals immune against tuberculosis. Behring attributes the immunity of frogs against the bacillus anthracis to the degree of alkalinity of the blood. Buchner has put himself at the head of a school of investigators who claim chemical microbiocid properties for the blood serum. In opposition to these theories of the neutralization of morbid activities stands the theory of phagocytosis.

Recent experiments with the virus of the anthrax in pigeons mark a new phase of this theory. That pigeons are refractory to the bacillus anthracis has been proved by numerous observations, and explained according to the several modes of accounting for immunity in general. For example, Hess invariably verified phagocytosis, while the Baumgarten school absolutely denied the intervention of the

destructive white globules. Another interesting side of the controversy was the determination whether in the passage through the organism of the pigeon, the anthrax virus undergoes an attenuation, as affirmed by Omller and Kitt, or a reinforcement of virulence, as asserted by Roux.

Metschnikoff's experiments show in the clearest manner that repeated inoculation imparts a progressive potency to the bacterium which traverses the pigeon's organism. But the demonstration of particular importance to phagocytosis was the constant infiltration of leucocytes at the point of inoculation, proving that the micro-organisms were taken up by the macrophagi or polynucleate leucocytes, the protoplasm of which is not adapted to common aniline coloration, and by macrophagi, or white cells of one nucleus, the protoplasm of which reacts with methyl blue. The strife between the micro-organisms and the cells was manifested with the most complete accentuation. The micro-organisms frequently showed signs of incipient degeneration, while phagocytes were as frequently observed which had lost their power of vital resistance. That the bacilli were generally living when absorbed, Metschnikoff proved by their mobility, by their reaction with an old solution of vesuvin, and by the following experiment: He put a drop of exudation taken from a pigeon into broth heated to a point which annihilated the life of the phagocytes while permitting a luxuriant development of germs, which he followed through the various successions of bacillary development. To demonstrate the virulence of the germs he obtained cultures of bacilli contained within the leucocytes.

In conclusion, Metschnikoff does not claim exclusiveness for his theory. He does not consider one isolated fact sufficient to explain the complex vital phenomena of immunity, and he has always conceded that the progress of investigation may lead to the determination of other interesting factors of immunity, phagocytosis remaining the principal

phenomenon of the process.—*Abstract of Sanitary Reports.*

SALOL IN DIAGNOSIS.

A curious use of salol as a diagnostic agent is made by Pal, of Vienna. Acid compounds of phenol are broken up by the secretions of the pancreas and of any other part of the intestinal canal, except the stomach. If, then, salol be given, and the urine responds to the tests for salicylic acid, the salol has passed the pyloric orifice. In two cases where this reaction was not given, occlusion of the pylorus was diagnosed; and this was confirmed by the autopsies.—*Times and Reg.*

TREATMENT OF ACNE OF THE FACE.

The most rational treatment of facial acne should be based upon the following two principles; first, to allay the congestion of the skin as far as possible; second, to remove all causes which could give rise to the hyperæmia of the face. To obtain these results, both internal and external remedies may be used. The direct care of the skin demands the principal attention. Every morning and evening the face should be washed with a fine sponge. The temperature of the water should be as high as the patient can possibly bear it. After washing, the skin should not be dried. Such a washing renders the skin extremely hyperæmic. As soon as the water begins to evaporate from the face, the superficial blood-vessels become contracted, and gradually regain their lost tone. In many cases, this simple treatment will be all that is needed, and a speedy recovery will follow. In severer cases, however, the following solution may be employed:

R Hydrag. bichlor. corros. Ammon. muriat. ää gr. xv
Emuls. amygdal. amar. f 3 vij
M. et flat lotio,
Sig. Apply morning and evening.

The following formula will be found to be of equal if not of greater efficacy:

R	Aquæ destil.	f 3 jx
	Sulphur. sublim.	f 3 j
	Aetheris sulfuric.	f 3 iij—3 jv
M. et flat lotio. Sig. Apply morning and evening.		

The practitioner may, however, come across cases of such a stubborn nature that even these lotions will fail to effect a permanent cure. In such cases, the only remaining course of treatment is scarification. This procedure never fails to quickly relieve the congestion of the skin, and also causes the acne pustules to rapidly disappear.

Regarding the best advisable diet to be pursued during the treatment of acne, little need be said, other than the highly spiced and heating foods should be avoided. *Allg. Med. Central-Zeitung*, Oct. 7, 1889 —*Med. and Surg. Report.*

END OF THE SEASON AT THE SPA.

There is always the same dialogue at the end of the season at European mineral springs, *i. e.:*

“Doctor, I come to take leave of you.”

“Already?”

“Yes. I have finished my twenty-two days’ course of treatment.”

“Well, how do you find yourself?”

“Oh about the same.”

“Wait until you arrive in Paris; then the good effects of your stay will be manifest.”

“Do you really think so Doctor?”

“I am sure of it. But one season here is not enough, for the first visit requires a second in order to fully evidence the good effects of our hydropathic treatment. This is only the prelude of what will follow.”

“Ah?”

“Yes. It will be dangerous to remain in Paris too long before returning here. Your organization has received a stimulus that must find an echo in your return next season.”

“But, Doctor, I was assured that you would cure me.”

“Why, certainly. But your cure will

be more artificial than genuine until next season. Until I bleach you out you will not be *perfectly* cured."

"Bleached? well I think I am rather pale already."

"True, but you must return next season when you are stronger. Then you will really have confidence in me."

"Doctor, have you my bill ready?"

"Yes. Here it is.

The patient looks at the exorbitant charge and really turns deathly pale, and the doctor remarks: "Come again."—*The Cincinnati Lancet-Clinic.*

GOING FAST.

Hood used to tell a story of a hypochondriac, who was in the habit, two or three times a week, of believing himself dying. On a certain occasion he was taken ill with one of his terrors while out riding in his gig, and happening at the time to see in the road ahead his family physician riding in his carriage in the same direction, he applied the whip to his horse to overtake the old doctor as soon as he possibly could. The doctor, however, seeing him coming, applied the whip to his own horse, and as he had a nag that was considered a "goer," they had a close time of it for about three miles. But the hypochondriac, driving a fatter horse, finally came alongside of the doctor, and exclaimed, "Hang it, doctor, pull up—pull up instantly. I am dying." "I think you are," cried the doctor; "I never saw anyone going so fast."—*Tor. Sat. Night.*

CREOLIN IRRIGATIONS IN DYSENTERY.

The encouraging results obtained by Kortum, Neudorfer, and Esmarch in the treatment of dysentery with irrigations of a creolin solution, have recently lead Dr. Nicolaï P. Ossowsky to test its efficacy in a large number of cases of the disease occurring in soldiers. His experiences with the drug, which are reported at length in the *Gazette Hebdomadaire*, October 4, 1889, were most satisfactory. In every instance the treatment was

followed by a speedy and complete recovery. In many cases all symptoms of the disease disappeared in two or three days; in few only was necessary to continue the treatment for a week.

The irrigations were made two or three times a day, according to the severity of the case, and a one-half per cent. solution of creolin employed. Ossowsky used a long rubber catheter in giving the irrigations so that high portions of the bowel could be reached.

Dr. Kolokoff, of St. Petersburgh, has likewise used the drug in a large number of cases with equally happy results.—*Medical and Surgical Reporter.*

TREATMENT OF GANGLIA.

Dr. Barth has successfully treated ganglia, lipomata, and other small tumors by injecting one or two drops of Fowler's solution, after disinfection of the surface. The injection is followed by considerable pain and swelling of the cyst and periphery, but these soon subside and the tumor diminishes rapidly in size. The procedure is indicated in the case of patients who are unwilling to submit to a bloody operation; its chief disadvantage, the pain, may be prevented by adding to the injected fluid an equal quantity of a 1 to 2 per cent. solution of cocaine.—*Union Medic.—Canada Med. Record.*

ENUCLEATION OF THE EYEBALL AVOIDED.

In a note by Dr. Galezowski, the well-known ophthalmologist, the author expressed it as his opinion that it was possible to avoid the enucleation of the globe of a lost eye and to leave it in the orbit, at the same time avoiding the dangers of sympathetic ophthalmia. He realises this by suppressing all the anatomical relations of the diseased eye. The operation is performed in the following manner: He inc's the conjunctiva and the capsule, draws forward the globe of the eye, partially divides the optic nerve, and excises all the nerves and the vessels which surround the eyeball, leaving all

the muscles intact, and the operation is terminated by reuniting the conjunctiva. In a case thus treated the result has been excellent.—*Lancet.*

TOO MUCH EATING.

We called attention last year to an editorial, which was widely noticed in our exchanges, to the fact that on this continent people do not drink enough water. We would like at present to draw more general attention to the amount of injury people are doing themselves by over-eating. Even medical men hardly seem to realize how much more people eat than they can possibly burn up, and the consequences are deposits of fatty or nitrogenous compounds in various parts of the body where they do more or less harm. The mere laying on of a hundred weight of fat would not be such a great misfortune were it not for the fact that a part of it will be accumulated on the heart, rendering exertion so distasteful to the owner that the muscular system soon begins to suffer seriously by degeneration. Then again, nitrogenous food should be completely converted into urea, for the removal of which the kidneys and skin are quite competent; but when there is more nitrogen in the blood than there is oxygen to convert it into urea, it forms intermediary products, such as uric acid, which are much less soluble than urea, and of which the blood at a temperature of one hundred can hold just so many grains to the ounce and no more. Now if this supersaturated blood should, while passing through the hands or feet, become cooled down to 90 or 80, or even less, it is clear that so many grains of acid will be deposited at the place of cooling. If this deposit be examined under the microscope it will be found to be composed largely of sharp pointed crystals, which getting in between the smooth and sensitive surfaces of joints and tendons and passing through fine tubules of the kidneys, cause pain and sometimes inflammation. We have here the key note to

rheumatism, gout and Bright's disease. If we want to cure rheumatism we have only to cut off the nitrogen and turn on the oxygen and water and immediately the uric acid will be dissolved out of the joints and turned into urea and passed out by the kidneys. Some physicians think that they are carrying out these directions when they put the patient in a hot, close room on a strictly milk diet, or as the patients themselves often say, they are left to starve on four quarts of milk a day, and not a bite to eat. But milk diet is about the very worst diet we could possibly give a rheumatic patient. The four quarts of water are all right, but the four thousand grains of cheese, three thousand grains of fat and two thousand grains of sugar are of no advantage to a person whose blood is overloaded with surplus products which have never had a chance to be consumed. The best diet for a rheumatic patient is four quarts of water made into gruel, without milk, by the addition of a very small quantity of well boiled oatmeal and a little sugar. This pacifies the eye, satisfies the stomach, and, above all, gets the saving four quarts of water into them while keeping the injurious meat, cheese, milk and other nitrogenous food out.—*Canada Medical Record.*

GONORRHœA AND ITS SEQUELÆ

The general public have little or no idea of the disastrous consequences which result from gonorrhœa. It is sometimes considered rather a joke when a male gets "caught" with an ordinary clap, as it is called. If it be "cured" in a few weeks, it is thought to be a thing of the past, trifling in its nature, though it caused considerable inconvenience and pain for the time being. There may be a slight gleet, which is generally considered a considerable nuisance, but not a very serious matter. Such a condition is, however, a very serious one indeed, and the consequences are pretty well known to the profession, though perhaps not always appreciated to the fullest ex-

tent. The most serious of these arise from the urethral stricture, which follows in a large proportion of cases, and are cystitis, pyelitis, and serious lesions of the kidneys. These results may be delayed for many years, and are apt to become more troublesome at an age when the vital energies are becoming impaired, and consequently less able to resist them. In an old man a stricture with a cystitis, causing him to spend a goodly portion of his time during night and day in his efforts to force his stinking ammonical urine through a canal that is almost closed, is accompanied by an amount of suffering that is simply indescribable.

On account of such serious results connected with the sequelæ, it has been stated by some, that gonorrhœa causes a greater amount of evil to the human race than syphilis. In answer to this, we may say that such a statement is absurd when it is considered that syphilis causes not only suffering to the patient, but serious evils to his descendants for many generations.

Unfortunately, as we are learning during the last few years, the evils resulting from gonorrhœa in males are by no means confined to the men who are simply paying the penalties for the follies of youth. Their wives in a large number of cases have to become the innocent sufferers. Some years ago Nøggerath surprised the medical world by the statement that more than half the women of New York were suffering from disease resulting from gonorrhœa. Such disease is frequently caused by the husband, who formerly had one or more attacks of clap which had been *cured*. The usual course of events in the female is vaginitis, endometritis, salpingitis, and peritonitis, with frequent purulent formations. Recent abdominal surgery has done much to prove that Nøggerath was nearly, if not absolutely correct. *It is inexpressibly sad to see a healthy, happy girl, who becomes a loving and faithful wife, changed from such causes in a few years to a hopeless chronic invalid.*

The lesson to be learned by the profession is obvious. Always consider gon-

orrhœa as one of the most serious of all diseases. The physician is frequently, if not generally, handicapped by the secrecy which surrounds the case, and often prevents that rest which is indispensable in treatment. One is terribly nonplussed in certain cases, and it would probably be much better frequently to throw aside the secrecy, to some extent at least, but as a rule this must not be done without the patient's consent. We are not going to discuss treatment, but in a general way would say—put your patient in bed at once and cure him as thoroughly and as quickly as possible.

—*Canadian Practitioner.*

FATAL HÆMORRHAGE FROM LACERATION OF THE VULVA.

Dr. Drzmalik has noted, in the *Wiener klinisch. Wochenschrift*, a case of great medico-legal interest. The patient was a woman, aged 24, in the eighth month of her first pregnancy. She was seized with faintness in a hall of a house, leant against the wall for support, but gradually slipped down on to the ground with her thighs extended. She was picked up unconscious and bleeding, and soon died. No trace of violence could be found on the body. The thorax was not opened. The uterus was found enlarged to the usual degree at the eighth month of pregnancy. It contained twins, with distinct placentæ inserted high up on the side of the uterine wall. The cervix was plugged with mucus. Immediately above the meatus urinarius was an angular laceration, the meatus lying close to the apex of the angle. There was no trace of any other injury, Dr. Drzmalik felt confident that the wound was the source of hæmorrhage, and of this there could be little doubt. He further was satisfied that the wound was caused by sudden extreme abduction of the thighs.

—*British Medical Journal.*

THE TREATMENT OF ENDOMETRITIS WITH CHLORIDE OF ZINC.

(Moret, *Jour. de méd.*, Feb. 9, 1890).

—1. The vaginal and uterine canal should be cleansed with a solution of

sublimate.

2. The cervico-uterine canal should be sounded with a smooth, flexible bougie, which is better for this purpose than the uterine sound, for it is not likely to wound the mucous membrane.

3. The bougie having been withdrawn, its curve is to be noted, and then one should introduce a pencil composed of three parts of rye flour and one of chloride of zinc. The pencil should be four to six millimetres in thickness, and should penetrate as far as the fundus.

4. The posterior vaginal *cul-de-sac* should be tamponed with absorbent cotton impregnated with iodoform, and the remainder of the vagina with ordinary non-absorbent cotton.

This treatment may be followed by pain, slight fever, and possibly by transient retention of the urine. In ten or twelve days the sough produced by the caustic will be discharged. After its expulsion the uterine cavity should be dilated with a No. 15 bougie, and the size should gradually be increased to 21 to avoid contraction and dysmenorrhœal pain. During the following month irrigation should be practiced daily with sublimate solution.—*New York Medical Journal.*

Medical Items.

Kemmler's electrocution did not go off very smoothly.

Dr. A. H. Mann Jr., who has been so ill at Vienna, is convalescent and will return to this country in a short time.

The next International Medical Congress will be held in Rome in 1893. It is to be hoped it will not be in August.

The next meeting of the American Society of Microscopists will be held at Detroit, Michigan, August 12 to 15, inclusive.

Dr. Laveran, of the Val-de-Grâce Hospital in Paris, has received a prize from the French Institute for his researches on the haematozoa of malaria.

The College of Physicians and Surgeons of this city, has issued a particularly attractive annual announcement. Its facilities for instruction are wonderfully improved in the past year.

The State Board of Health does its duty unflinchingly, and the dishonest milk dealers who have been warned, are awaiting their trial with fear and trembling.

In the German Empire, during the past five years, there has been an increase of 25 per cent. in the number of cases of insanity, against an increase of 3.5 per cent. in the population.

On account of ill health, Dr. H. E. Knipp of this city, will sell his horse, carriage, and practice, to a great advantage. For further particulars apply or write to 523 Scott Street, Baltimore.

A suit for malpractice was brought against Dr. McKinnon, of Selma, Ala., about a year ago, the case being one of fracture. A verdict was promptly rendered in favor of the defendant.

It is estimated that the loss of wages due to influenza in London amounted to five million dollars, and a like amount was paid out in insurance and sick-dues by the different mutual aid societies.

The British Medical Journal says that, in consultations, the ordinary medical attendant should invariably lead the way, and should first enter the sick chamber. On leaving the room, after the interview is over, this order should be reversed.

The Liston Victoria Jubilee Prize has been awarded to Robert Lawson Tait. It was open to all fellows and licentiates

of the Royal College of Surgeons of Edinburgh, for the greatest benefit done to practical surgery by any of these during the triennial period ending June 20, 1890.

Dr. William Osler of the Johns Hopkins Hospital has been attending the British Medical Association and the International Medical Congress. He is paying a hasty visit to the more important German Universities, and will return in the late fall.

The young doctor should form the habit of writing and reporting his cases while he is young. Very few men learn to write when they are old, or feel inclined to write after they acquire a large practice, unless they do so from force of habit.

The *Medical Record* says that Sir Morell Mackenzie, who it was supposed would lecture in this country next October under the management of J. B. Pond, has sent word that his health will prevent him carrying out his engagement. He offers to come next year, however.

The Committee on Dr. Freire's claim to have discovered the yellow fever germ, report to the Section of State Medicine of the American Medical Association, that Dr. Freire's claim to have discovered this germ and his ability to prevent the disease by inoculation, still needs verification; and that Dr. Sternberg's diligent and experimental study convinces the Committee that the germ of yellow fever is yet to be discovered.

The fast of Signor Succi for forty days, which from all accounts seems to have been genuine at least, proves that people would not be in danger of death, as many of them think, because they went without food for a few hours or even a whole day. The hard working stone-breaker seems to be able to work ten hours a day on what others, who do no work at all, would think they were being starved on.

In Elmira, New York, physicians are obliged to report all contagious diseases to the health board, who then cause signs with the name of the disease entered thereon to be placed in a conspicuous position on such houses as have contagious diseases therein. These signs of "measles," "scarlet fever," &c., can be easily read two squares distant. Notification is also published in the press.

Dr. Arthur D. Mansfield of this city, has been spending the past few months at St. Bartholomew's Hospital, London. He expects to take a short trip in Switzerland this summer, and in September, will begin his work by studying at Berlin for half the winter, and then going to Vienna. In the spring he will return to this city and take up practice with his father, Dr. R. W. Mansfield of South Broadway.

The *Medical Record* says that seventeen fatal cases of poisoning from antipyrine occurred in one week in Vienna during the prevalence of the influenza. In many of these cases the drug was bought by the victims themselves without a physician's prescription; but, partly in consequence of these fatalities, it is now illegal to sell antipyrine except upon a written prescription from a physician.

The *London Photographic News* says: Photography has attained a recognized position in medicine. Fac-simile reproductions from photographs form a special feature of the *Illustrated Medical News*: there are amateur photographers on the staff of nearly every hospital, and the extensions now being carried on at the Royal College of Surgeons now comprehend a "photograph room." The department has already been opened, and was alluded to by Mr. J. Hutchinson, the president, at the annual meeting of the college held last week. Before long the surgeon will think more about carrying his camera than he does now of carrying his stethoscope.

MARYLAND MEDICAL JOURNAL.

VOL. XXIII. No. 16. BALTIMORE, AUGUST 16, 1890.

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QUININE, THE PANACEA IN INTERMITTENT FEVER; VERY LARGE DOSES UNNECESSARY AND WASTEFUL.*

BY W. STUMP FORWOOD, M. D.,
OF DARLINGTON, MARYLAND.

Through all these years we well remember the language of experience, and sympathy uttered by our friend and neighbor, Dr. S. B. Silver, who himself a long sufferer from ill-health, is now "after life's fitful fever," changed to a state of peaceful rest,—spoken in a conversation at the beginning of our professional career, thirty-six years ago. Referring to the relations existing between the physician and the patient, and to the proper appre-

ciation on the part of the former, to the varied, and often vexatious complaints of the sick, he said: "Doctor, that physician is the best qualified to comprehend the nature and the responsibilities of his profession, and also to successfully treat the sick, who has himself suffered with the pangs of disease. He is thus brought into a *personal sympathy* with his patients in their sufferings, which fortifies his forbearance to endure with becoming equanimity the oft-times tedious recital of the ills inflicted upon poor humanity."

This remark, made by our friend so many years ago, is now recalled to memory by the similar thought, deeply impressed, by painful experience upon our own mutual organism, viz.: that it is impossible for a physician, however cultured or experienced, to *fully* comprehend or appreciate the value of *quinine* or its elements, and the peculiar and special methods of its application and administration in disease, who has not himself been the victim of *intermittent fever*.

*Read before the Medical Society of Clarke County, Ala., April 16th, 1890; and recommended by the Society for publication.

In our experience as a patient, and subsequently in our extended observations as a practitioner of medicine, we know of no disease, not necessarily fatal in its termination, that renders life so miserable and so utterly wretched as the condition resulting from a protracted case of *chronic intermittent fever*.

Happily for the human race, the discoverer of cinchona and its salts, discovered the remedy for this hitherto intractable disease.

The use, and abuse of quinine, in the treatment of *malaria* proper, will constitute the theme of the present paper, and only such practical facts will be stated, in connection with the use of this medicine, as have been time and again demonstrated and verified by a very extensive practice in the treatment of hundreds of cases of malaria, and by a very painful personal experience in suffering, day after day, week after week, and month after month with that wretched, almost incurable, and "won't-stay-cured" disease, commonly known as "*ague*."

The determining reason, suggesting the present expression of our views upon the use of quinine, as the result of a wide experience, has its origin in the recent re-reading of a valuable paper published in the *Philadelphia Medical and Surgical Reporter*, May 5, 1888, by my highly esteemed friend, Dr. Hiram Corson of Conshohocken, Montgomery County, Pennsylvania, entitled "*Quinine; its Use and Abuse*."

All who feel an interest in learning how much good can be, and has been accomplished in the successful treatment of remittent, and intermittent fevers by comparatively small quantities of quinine, such as were only attainable at the time when Dr. Corson was a student of medicine, when that panacea was then selling at \$16 per ounce, and had been as high as \$26 per ounce in the experience of his preceptor, should carefully read these statements of Dr. Corson, a conscientious and reliable observer and author.

As the present paper is primarily intended for presentation to the *Medical*

Society of Clarke County, Alabama, it would appear proper to offer the results of a series of observations and experiences which occurred to the writer while residing within the bounds of that state and county, and our remarks will, of necessity, be largely composed of personal history, which, at our age, can scarcely be considered as trenching too broadly upon the bounds of modesty.

We were born and reared in the vicinity of our present residence, Darlington, Harford county, Maryland, in a location where neither remittent nor intermittent fevers prevailed.

At the age of eighteen, in the spring of 1848, while in the enjoyment of robust health, we removed to, and took up a temporary residence in Clarke County, Alabama.

Some precautions were taken in the early days of summer, by the advice of the old residents, to "avoid the night air" on the river and marshes; but in spite of all the precautions that appeared to be practicable, we suffered a dreadful attack of bilious fever before the first summer was half over. Never having experienced any sickness previously, except some of the brief disorders of youth, this attack of fever, with its nausea, headache, thirst, and delirium through the long night, produced a state of feeling, the utter wretchedness of which it is impossible to describe to those who have not suffered in like manner. And then the nauseating medicines to be taken! —febrifuges, mercurial carthartics, and quinine, that were administered with painful frequency, banished whatever little rest of palate and brain that we might have enjoyed in the brief intervals of subsidence of headache and fever, and, together, united in producing a degree of discomfort and misery that rendered life unendurable.

We were fortunate in having excellent medical advice and attention, and after about three weeks of suffering, we were able to arise from bed, in a state of prostration never previously experienced.

Appetite slowly returned, and after

several weeks' confinement to the house, and to the immediate surroundings, we concluded that our health was restored, and were encouraged by the old residents as to the future, by being informed that the first summer in this climate, was always the worst upon the constitutions of those who came from a more northern latitude, after which, it was promised, the new-comers would become "acclimated." Alas! Vain hope!

Early in the autumn of the same year, 1848, disagreeable sensations hitherto unknown, with headache, and burning skin, came on, and increased each day, until finally we were obliged to give up, go to bed, and apply for medical treatment. The physician informed us that we had been suffering with "dumb ague." Very soon it found its tongue, and the chill and the fever soon became painfully pronounced, with vomiting, and headache, and the attendant wretchedness, with comparative relief on the alternate days, except the feeling of weakness resulting from the hot fever and exhausting "sweats."

After battling with this intermittent fever, with varying results, and keeping it at bay by ten and fifteen grains of quinine, daily, from the alternate days to once in a week, and once in two weeks, it was finally conquered "after frost."

The conjectures of sympathizing friends in regard to security in the future against recurring attacks of the fever after a year's *acclimatization* proved in our case illusory, erroneous, and vain, for our attack of bilious fever in the second summer was more violent than that experienced in the first, and its intermittent continuation proved more protracted and intractable than it had done in the first year.

But to crown our distress, to place "the last straw upon the camel's back," and destroy the last glimmer of "hope deferred," *the third year's remittent, and succeeding intermittent* fever, surpassed its predecessors in virulence of degree, and in tenacity of hold, continuing in the intermittent form, with various inter-

ruptions interposed to its course by the antiperiodic action of quinine, *fully nine months* from its beginning, compelling us at the end of three years, for the preservation of life, which now appeared to be scarcely maintainable or desirable, to leave the state and return to the more healthful surroundings amid which were passed the happier days of our youth.

At the beginning of our sickness in the first year, our stomach being naturally strong, would readily receive and retain quinine, and the various "bitters" advised (oh, how bitter now, even in remembrance!) in almost any quantity, with but very slight repugnance of taste, but during the second, and especially during the third year, the weakened and sensitive stomach and embittered palate could scarcely be induced to retain these nauseous medicines for a moment, thus painfully adding to the almost unendurable wretchedness of the disease itself. And even to the present day, forty years after the experiences we are now narrating, our stomach will not retain the smallest dose of quinine, except it be administered in capsules or otherwise disguised in its taste; and even then a sense of stomachic distress and nausea supervenes.

During the last year or two of this residence and suffering in Alabama, that excellent physician and noble man, Dr. G. W. Files, then at the beginning of his afterwards successful career as a practitioner, was our medical adviser and friend; the friendship continuing and increasing in strength until the day of his death, which unhappily occurred in the past year, 1889.

Dr. Files having been reared in a section of the country where bilious and intermittent fevers regularly prevailed (Wilcox county, Ala.), and having enjoyed the advantages of a good medical education at the colleges of Louisville, and of New Orleans, was well equipped for the successful treatment of malarial fever, and from him we learned many valuable lessons in regard to the nature and the treatment of this most obstinate dis-

ease, applied to our painful experiences, before we regularly entered upon the study of medicine.

Although Dr. Files was, at that time, in the habit of administering much larger doses of quinine than our subsequent experience in practice taught as necessary, yet he very rarely prescribed more than eight, twelve, and fifteen grains at a dose, four times within twenty-four hours.

It was the "fashion" of the country at that time for many practitioners to administer 20 grains and 30 grains at a dose, and repeating the same every three or four hours,—a fashion happily abandoned, to a great extent, of late years, as useless, and wasteful.

It was not until we left the country that we finally got rid of the disease, having had a "chill" on the very day before our departure, which was the latter part of April, 1851; and although we were provided with a box of quinine pills by our good friend, and physician, we never had occasion to take a dose of them afterward.

These dreadful assaults upon our health by the native diseases of the unfriendly climate of the South, changed our future plans of life. We returned to Maryland, and immediately began the study of medicine, determining to master every means by which to conquer our old enemy, *Intermittent Fever*. Our subsequent experience of thirty-six years has demonstrated the success of our endeavor. With the co-operation of the patient, which is always essential, we have never failed to arrest the disease within twenty-four hours after the beginning of treatment, if a case of recent origin, or within forty-eight hours in cases of longstanding, and in the most chronic condition.

It was not our purpose at the beginning of this paper to enter upon a discussion of the full details of the use of quinine in the treatment of intermittent fever, but we were influenced by the special object of showing, from our own personal experience, that the malady may be

cured by comparatively small doses of the remedy, when systematically administered, in connection with proper hygienic precautions.

We learned, in the first place, from the instructions, and from the practice of Dr. Files; as, also, from our own sufferings, that, in order to prevent the return of the "chill," *the system must be under the influence of the anti-periodic effects of quinine at the time that the chill was expected to occur, if uninterrupted by treatment.* The teachings of the lecturers, and of the books on practice, concur upon this point; but the latter do not generally emphasize the fact as strongly as our experience has taught to be necessary.

Since beginning the practice of medicine, we have had wide experience in the treatment of intermittent fever; and have always approached a case with the deepest sympathy for the sufferings of the patient, and with anxious solicitude for the accomplishment of a speedy cure.

After an experience of fifteen years in the treatment of intermittent fever along the banks of the Susquehanna River, and the associated Tide-Water Canal;—about two and a half miles distant from Darlington, at a time when the disease was much more prevalent than at present, we removed again to Clarke County, Alabama, on higher, and more healthful ground, and surroundings than was the location of our previous residence there; and we there practised our profession for about three years, between, and partly inclusive of the years 1870, and 1873.

Then our field of practice largely consisted of malarial fevers, especially in the intermittent form. It was not a common experience to prescribe for ten or twelve cases of the latter daily, which cases occurred chiefly among the negroes, during the summer and autumn. To give a practical exemplification of our treatment in its details, we hope will serve others with a ready knowledge at the beginning of their labors, without undergoing the years of observation, and painful experience through which it was obtained. It will

be seen that our successful treatment of intermittent fever, with comparatively small quantities of quinine, fully concurs with the experience of Dr. Corson so graphically narrated in his article on the "*Use and Abuse of Quinine*," referred to at the beginning of this paper.*

Upon being called for the treatment of intermittent fever, it is our rule to ascertain, in the first place, the frequency of the return of the "chills," and the exact hour of their occurrence. We then administer quinine at longer or shorter intervals, or in larger or smaller doses, according to the length of time at our disposal from the hour of our first consultation, to the hour of the expected return of the chill, always allowing in our calculation, *one hour for its earlier return each day*, in accordance with a very well established rule in the habit of this disease. In treatment, we invariably make it our prime object to *stop the chill*; and not to waste valuable time, as was formerly taught and practised, in clearing the primæ viæ, by mercurial cathartics, and in preparing the system for quinine, *but to administer the quinine at once*; the system being always in condition to receive it when invaded by malaria; and, after succeeding in the interruption of the periodicity of the disease, by the prince of anti-periodics, quinine, we *then* give a gentle mercurial purge, two or three grains of calomel, with a little rhubarb, or a corresponding dose of compound cathartic pills, U. S. P., to be repeated, to remove the surplus secretion of bile, which usually exists in such cases, as the name, "*bilious*" fever, implies.

The cathartic should be repeated every two or three days for a week, or more, the doses, and the frequency of their administration, to be regulated by the peculiarities of each individual case.

Very active, and powerful cathartics are much more injurious than beneficial

in this disease, exhausting the vitality of the patient.

We advise the immediate dose of four grains of quinine, and that to be repeated every four or six hours, until twelve, or sixteen grains have been taken within the twenty-four hours; and that quantity must be taken within the first *twelve hours*, if we should be limited to that time before the return of the anticipated "chill," on the first day, for it should ever be our aim to stop the *chill* at the earliest possible moment. After that is done, we use the 24, or 48 hours' interval, as the case may be, by distributing the twelve to sixteen grains of quinine through each twenty-four hours, so as to maintain the continuous, and culminating effect of the medicine until after the regular hour for the "chill."

For instance; if a patient presented himself for the treatment of *ague* at 12 o'clock to-day, in anticipation of a "chill" at 12 o'clock to-morrow, 24 hours hence, we would prescribe three grains of quinine at once, three at 4 o'clock P.M., and three at 8 P. M. Then we would begin with the same dose at 6 in the morning, to be repeated at 8 and 10 A. M. *the patient to remain in bed, covered warm*, until the "chill time" shall have passed by at least two hours. This would be eighteen grains of quinine for the first day, and in nine cases out of ten that quantity, given at the hours stated, will arrest the "chill." Even in cases of long standing, this treatment will so modify the subsequent attack, if any, as to render the repetition of the treatment perfectly successful in the succeeding twenty-four hours. If there be no return of the "chill" after the first or second day's treatment, we can then reduce the quantity of quinine to twelve grains daily, divided into proportionate doses, and given at the same hours, until three or four "chill days" have passed without return of chill. We may then, say at the end of a week, if the case be a chronic one, reduce the quantity of the medicine to nine grains daily; three grains to be given at a dose three times daily,

*Two or three correspondents of the *Maryland Medical Journal* have asked for information as to the exact doses of quinine required in the treatment of intermittent fever, since the preparation of this paper. The information is here given in more practical detail than any that we have ever seen in print, and we hope that substantial benefit, and satisfaction will be derived from its careful study.

just before each meal. This treatment should be continued three weeks, and longer, if the case be one of long standing. *The usual cause of failure is that the regular use of the quinine is discontinued too soon.* Then, for one week longer, give three grains before breakfast, and three before supper; and for the succeeding week, or for a longer period, if it still be in the "sickly season," give three grains daily, at one dose, before breakfast.

These directions may appear trivial to those who have never encountered *ague*, and experienced the annoyance, and vexation of repeated failure in its curative treatment; but to the young physician practising in an ague section of the country, these rules, if observed, will prove a priceless boon.

With the adoption of this treatment, pursued exactly as here laid down, in which it will be perceived that more than twelve grains of quinine are scarcely ever administered within twenty-four hours, after the first two or three days, we have been uniformly successful in curing this obstinate disease in cases where our advice has been strictly followed, to the extent of 99 per cent. in thousands of cases. Indeed, we do not remember a single case, in which our treatment was faithfully practised, that did not promptly recover.

Of course, cases have occurred in our experience where our treatment, and rules, have been only partially observed, or wholly neglected, and with corresponding results.

As to the positive efficacy of twelve or fifteen grains of quinine, per day, for the cure of the most obstinate case of intermittent fever, our wide experience, spread over so many years, with such a strong incentive to the study, as we had at the beginning, has proven beyond a doubt.

It is a remarkable fact, that we do not remember to have seen mentioned in the "books"—though it doubtless has been—which has often been presented within the field of our observation, that a fresh attack of ague, even many weeks after the

return of the last chill, is almost certainly to be brought about by exposure to a shower of rain. Therefore, we always make it a rule to instruct our convalescent patients to avoid the rain; or, if this be impossible, to hasten home, change clothing, and take four grains of quinine immediately; and by so doing, they will usually be secured against the return of a chill.

As might be presumed, in our long experience in malarious districts, we have treated malarial diseases in all its aspects, from the light, easily managed cases, to the most violent and obstinate, cases that have existed from one to two years, by which the patient was worn to a shadow; having taken quinine, and every conceivable "remedy," but without order, or system, and, of course, without beneficial results. We have often met with such patients who would tell us: "Doctor, it is of no use to give me quinine: I have taken it time and time again, ten and twenty grains at a dose, without any benefit." We never attempt to argue, to convince patients "against their will," but simply proceed to prepare twelve or fifteen grains of quinine, in a disguised form, for their daily, and systematic use, and their ague is soon cured!

The enormous and injurious doses of quinine, twenty, thirty, and even sixty grains, that it has been fashionable to recklessly administer, as instanced by my friend Dr. Corson, are not only unnecessary for the purpose, and, therefore wasteful of a valuable medicine but, in many cases, work positive harm to the patient.

That fatal results have not more frequently attended the administration of the extravagant doses recorded as having been used in the treatment of malarial disease, is simply owing to what we believe to be a fact, that the entire quantity, in such doses, is not absorbed; the greater part being, fortunately for the patient, dejected unappropriated.

As already stated, our experience has proven, beyond controversy, that a greater quantity than twelve, or eighteen

grains, divided into three or four doses within the twenty-four hours, is never necessary in the treatment of intermittent fever.

In these remarks we do not include, nor refer to *congestive fever*, or more properly called *pernicious fever*, as named by our honored teacher, Prof. Geo. B. Wood. That is so rare a disease, and so extraordinary and fatal in its manifestations, and termination, that no fixed rules can be applied to its management, and treatment; the physician in charge being compelled to resort to such measures as the emergency appears, in his judgment, to call for. We have seen but one or two such cases in a life-time.

As will be seen, we have confined our remarks chiefly to the curative use of quinine in the treatment of that homely, very common, yet to many of our professional brethren, unmanageable disease, *intermittent fever*. If we shall succeed, through the light of our experience, most painfully acquired, in enabling our brother practitioners, through the instructions here given, to manage with ease and facility a disease hitherto regarded with so much anxiety, because of its "won't-stay-cured" qualities, we shall feel fully rewarded for the labor incurred in the preparation of our experiences, in a form available for the use of our friends of the Clarke County (Ala.), Medical Society.

Darlington, Md., April 9, 1890.

SUBMUCOUS RESECTION OF CARTILAGE IN DEVIATIONS OF THE NASAL SEPTUM. A NEW OPERATION.*

BY JOHN B. ROBERTS, M. D.,
OF PHILADELPHIA.

There are cases in which simple division of the nasal septum, with the use of pins to hold the divided partition properly in place, is not efficacious, be-

cause the cartilage contains too much tissue to be held in a straight line after its abnormal curves have been corrected. It is easily understood that, since the shortest distance between two points is a straight line, a curved or bent septum forced into a straight line by dilatation of the nostril or by incision, has a tendency to reproduce the curvature within a few weeks after the operation. In such cases it is usually necessary to remove a portion of the septal cartilage, if permanence is to be given to the straight position obtained by the operation. This is sometimes done by excision of a portion of the septum by means of a nasal punch or a knife, thus leaving an opening between the two nares. The operation which I describe, and which is a resection of the cartilage beneath the mucous membrane, makes no opening between the two nares, and yet gets rid of the surplus septal tissue.

The operation should be commenced by dilatation of the occluded nostril with the finger or a pair of dilating forceps; the mucous membrane covering the septum of the occluded side is then incised by means of a blunt tenotome. The incision should be a long curved one, with the convexity toward the floor of the nostril, and should be commenced as far back as is necessary to make a flap large enough to uncover the curved piece of cartilage. A flat, dull instrument is then slipped under the mucous membrane and used to separate this membrane from the triangular cartilage and vomer. A finger in the opposite nostril gives rigidity to the septum during the manipulations. After the large flap of mucous membrane has been elevated, a blunt-pointed tenotome is thrust under the mucous membrane, which hangs down like a curtain, and is used to cut out an elliptical portion of the septal cartilage corresponding in size with the angle or curve in the deviated septum that the surgeon desires to remove. During this stage of the operation the little finger of the other hand in the opposite nostril is used to prevent perfora-

*Read before the Philadelphia County Medical Society, May 14th, 1890.

tion of the mucous membrane in the nostril opposite that of operation. A blunt instrument is then thrust through the incision in the cartilage, and used to separate the portion of cartilage, which is to be taken out, from its mucous membrane on the side opposite the occluded nostril. The elliptical piece to be resected is then lifted out with forceps and the large flap of mucous membrane permitted to drop in place like a curtain. One or two sutures of catgut may then be put in the mucous membrane at the anterior portion of the wound in order to hold the flap in place.

The operation is readily performed, and seems to me a distinct improvement in nasal surgery. So far as I know it is novel.

My observations have led me to believe that a great many cases of crooked nose or occluded nares are not due to fracture or congenital deformity, but to interstitial growth of the septal cartilage. It is impossible to increase the area of a partition situated between fixed borders without causing the partition to assume a curve. The triangular cartilage cannot extend upward, downward, or backward, because of its margins in these directions being fixed, hence, when it increases in area by abnormal growth it assumes curves and distorts the anterior portion of the nose.

I have recently operated upon a case in which the crookedness of the nose was very marked, and had been increasing within the last few years. In this case it was quite evident that the deformity depended upon a double curve of the septal cartilage, which was apparently due to abnormal interstitial growth.

Submucous resection of the cartilage is, it seems to me, a good method for relieving many cases of nasal deformity. The removal of angular or curved portions of cartilage without cutting away the mucous tissue is an operation giving rise to no great haemorrhage, although, of course, the bleeding is free.

I show to-night an elliptical section of cartilage the result of an operation done

by this method. In this case, as the members will see, I cut out a portion of the bone as well as of the cartilage, and I subsequently removed another small piece of bone at the back part of the naris, by using a saw pushed under the mucous flap. The small portion of bone attached to the elliptical strip in the specimen, was removed by the incisions made with the tenotome. The anterior portion of the bone of the septum is so thin that it is easily cut through with a tenotome.

The relief of nasal obstruction was immediate and very satisfactory in this case.

A REPORT OF FIVE CASES OF PLACENTA PREVIA.

BY H. P. NEWMAN, M. D.,
OF CHICAGO, ILL.

Owing to the rarity of this condition—the frequency being computed at about one in one thousand pregnancies—the experience of any one man, except in the large Maternities, cannot be very extensive, but for this very reason is of greater value, since public records bearing upon the subject are meagre, though the question has always been one of great controversy. In the following five cases coming under my observation during the past four years, I regret that a more detailed account cannot be given, but the clinical facts are essentially these:

CASE 1.—A central implantation of the placenta, in which no haemorrhage occurred throughout the entire pregnancy until the very last days of gestation.

The patient, Mrs. B., a strong, healthy woman of middle age, has borne seven children, and had three miscarriages. With the exception of rapid childbearing, a laceration of the cervix, and one faulty presentation necessitating version, her former history has no particular interest. Ten days prior to delivery at term there was the first appearance of bleeding,

which was easily checked by the patient assuming the recumbent posture, and it was not until five days later that the haemorrhage became at all abundant. Delivery took place on Tuesday, April 13th, 1886. On the preceding Friday Dr. R. N. Hall was called, and diagnosed placenta previa, using the tampon.

I first saw the case in consultation with the doctor on Tuesday morning. The repeated tamponing and the use of the colpeurynter the night before had had the effect of gradually bringing on labor pains, and softening and dilating the cervix to the diameter of nearly two inches. A digital examination revealed nothing but a thick placental surface upon all sides, covering, as we afterwards found, the entire lower segment of the uterus. By bimanual palpation we made out a shoulder presentation (left dorso-anterior), and decided on immediate delivery.

Every preparation being made to control haemorrhage, the placenta was carefully separated from its uterine attachments upon the left side, and the right hand carried upward between the membranes and uterine walls. When the feet were reached the sack was ruptured, podalic version performed, and the child extracted. Meanwhile Dr. Hall had followed up the evacuation of the uterus by firm bimanual pressure through the abdominal walls. The placenta, which was a large one and pretty evenly distributed upon all sides, was separated from its remaining attachments and removed as speedily as possible.

The entire procedure was accomplished in less than five minutes, and the haemorrhage was not excessive considering the nature of the case. The child was saved, and the mother made a rapid recovery, being up and about the house within ten days.

CASE 2.—Also a case of central implantation. Mrs. W., a strong, hard-working Polish woman, about 35 years of age, having two living children and no miscarriages in fifteen years of mar-

ried life. Former pregnancies and labors normal, with the exception of laceration of cervix and perineum. The first haemorrhage took place June 11th, 1887—seventh month of pregnancy—and was attributed to the exertion consequent on caring for a sick husband. The flow was not excessive and was relieved by recumbency, uterine sedatives, styptics, etc. During the following six weeks three or four rather copious haemorrhages occurred at intervals of ten days to a fortnight.

July 26th the woman was delivered of a healthy female child, the medical attendant being Dr. J. C. Pickard. I was called in consultation during the last days of gestation, and, as there was rigidity of the cervix, advised use of the colpeurynter and cervical tampon to restrict flow and excite uterine contractions. These precautions being rigorously carried out, with full antiseptic precautions, a fair degree of softening and dilatation of the cervix was obtained, before the necessity for delivery became urgent, two days later. The bipolar method was employed, and delivery accomplished with little difficulty and a limited loss of blood. It was necessary to introduce the hand into the uterus to separate the placenta from its remaining attachments, which were found to constitute a complete circling of the lower segment of the uterus.

The mother's recovery was rapid, without complications. The child was in every respect a well developed, healthy infant, in no way prejudiced by the incidents attending its birth. It died, however, some weeks later from cholera, caused by the heat of summer with lack of proper food and attention—like so many others of its class.

CASE 3.—I was called to see this patient in the absence of the attending physician, Dr. J. S. Knox, to whose courtesy I am indebted for the subsequent history of the case.

Mrs. A., age 20; mother of five children. The first haemorrhage attracting attention occurred November 9th, 1888. This, and four or five following attacks,

covering a period of about six weeks, were controlled by rest in bed and appropriate remedies, until the morning of December 24th, 1888, when more serious flooding necessitated the use of the colpeurynter and tamponnade. The ensuing night the patient was delivered by Dr. Knox of a living child by means of combined version without anaesthesia.

This also was an instance of placenta previa centralis, and I am informed that of the woman's previous labors only two were vertex presentations, the others being brow, transverse, and breech respectively. The mother made a prompt and satisfactory recovery, but the child, being a seventh months' foetus and very feeble, died the following day.

CASE 4.—On the 27th of April, 1888, I was called to see Mrs. S., a middle-aged German woman, who was then in the sixth month of pregnancy. Had been taken with haemorrhage a few days previous, but had been kept in bed by a midwife, and the flow had ceased. As cervical canal was intact and rather long, and as child was not viable, it was thought best to temporize, and the usual remedies and directions were given. An attendant was provided and instructed to use the tampon in an emergency. A few days later I was called out of town, and left the case in charge of a neighboring physician.

On May 10th there was a recurrence of haemorrhage with advent of labor pains. The physician in charge could not be obtained, and through some misunderstanding of directions a substitute failed to find the residence of the patient. After eight hours' delay and constant haemorrhage, a local physician was obtained, and he proceeded to operate. Chloroform was administered and the patient died immediately. No attempt was made to remove the child from the uterus.

CASE 5.—Marginal implantation; Jewess, 23 years of age. History of one previous labor and one miscarriage. General health poor throughout this entire gestation. Was taken in labor October 21st, 1889, about 11 A. M.

As the distance from my house was great, I did not reach patient until late in the afternoon. I then learned from the midwife the particulars: The first indication of labor—full term—was a bloody discharge followed by pain and rupture of the bag of waters. After escape of liquor amnii the flow was materially lessened, and but little blood was lost from this time on until delivery. An examination showed edge of placenta attached low down upon right side of uterus, so that it could easily be felt through partially dilated cervix. Subsequent dilatation of os and engagement of head were slow and tedious, but no further trouble was experienced from loss of blood until the final delivery with forceps. The placenta, rather small and of the battledoar type, was adherent and with difficulty detached and expelled. The subsequent process of mother and child was in every respect satisfactory, and the latter is now vigorous and healthy.

I have but few observations to add. Care should be exercised in the choice of an anaesthetic, chloroform especially being a dangerous agent in cases where there has been much haemorrhage and the patient is exsanguinated and anaemic. Case 4 is a sad example of its ill-advised use, and it is probably owing to the rarity of the anomaly under discussion that there are not more accidents following the administration of this drug. Certainly, I have failed to find in any published literature upon this subject, a word of caution, or any mention of the restrictions to be placed upon its use in placenta previa.

My attention has been called to the possible merits of nitrous oxide gas as applied to these cases, having used it with very happy results upon a patient who had been extremely reduced by haemorrhages at and following abortion. The stimulating and strengthening properties of the oxygen were very apparent in this instance, and I would urge that it be given a trial in preference to other agents where an anaesthetic is indicated.

Again, as to the relative mortality of mothers and children in placenta previa,

in former times the fatality to both was appalling. But this was due in part to the fact that prior to the introduction of antisepsis all grave surgical and obstetrical procedures were more liable to terminate unfavorably, and in part to the faulty pioneer methods of treatment. The happy results obtained by some of our modern obstetricians have recently led more than one of them to remark that the terrors of placenta previa are much more overrated. Yet the fact remains that the fetal mortality is still as high as in the old methods.

The prevalent teaching is to favor that method which offers best results to the mother, "without regard," I quote, "to the life of the child;" and more than one author commits himself to the assertion that it is better deliberately to sacrifice the living child ("and we admit," he says, "that the child is sometimes directly sacrificed by this method") than that the mother's safety should be so much compromised in its behalf.

This attitude of obstetrical teachers, and the theory advanced almost unanimously that the only safety lies in immediate delivery, tend to engender a haste and rashness in terminating these cases which savors rather of the *accouchement forc *, or forcible delivery, of the early operators, than the judicious application of physiological principles to the indications in individual cases.

OVARIAN HERNI . THEIR CAUSES, SYMPTOMS AND TREATMENT.*

BY THOMAS MORE MADDEN, M. D.,
F. R. C. S. ED.

Physician to the Hospital for Sick Children, Dublin; Obstetric Physician and Gyn ecologist Mater Misericordiae Hospital; Examiner Conjoint Board Royal College of Surgeons and Apo thecaries' Hall, Ireland; Consultant National Lying-In Hospital; Ex-President Obstetric Sections of the Royal Academy of Medicine, Ireland, and of the British Medical Association; formerly Vice-President British Gyn ecological Society; M. D.
Honoris Causa Texas
Medical College, etc.

Ovarian herni  are amongst the most neglected, although clinically they should be included amongst the most important, of the troubles that come before us in gyn ecological practice. In the great majority of cases they occur downwards into Douglas' space, and in such instances the left ovary is that most frequently displaced. The next in point of frequency of these herni  are those occurring in the inguinal regions where they are either found above Poupart's ligament or, as is more commonly the case, follow the course of the canal of Nuck downwards and forwards, and so present in the labia where they may be readily recognized. In the former, or directly downward variety of displacement, the ovary may be discovered on vaginal examination in the recto-vaginal fossa as a small, oval-shaped firm, elastic and highly sensitive tumour, bulging forward into the post-cervical *cul-de-sac*. In the large number of cases of ovarian herni , especially those in Douglas' space result from the *vis a tergo* of abdominal and uterine tumours, or from the tension on the appendages occasioned by displacements of the uterus.

Diagnosis.—Until recently these herni  when inguinal were very gener-

*Abstract of a paper of Obstetric Section, read before the British Medical Association, July, 1890.

The House Committee on Invalid Pensions has agreed to report favorably a bill which provides that all women employed by the Surgical Department of the United States as army nurses or otherwise officially recognized as such during the late war, and who served in hospitals, in camp or on the battlefield for six months or more, and who were honorably discharged, and who, from the results of such service or the infirmities of advancing age, are unable to earn their own livelihood, shall receive a pension of \$12 per month.

ally confounded with enlarged glands; when labial, with other tumours in that situation; and when downwards, with pelvic abscess, and hæmocele. Or as often happens, they are mistaken for the retroflexed fundus uteri, and the patient suffering from an ovarian prolapse is vainly treated for a nonexistent retroflexion or retroversion of the uterus. There can now be no excuse for such errors. The sudden occurrence of the tumour, its physical character, the peculiar dull sickening pain, and the extreme tenderness and nausea manifest on examination, are sufficient to enable a correct diagnosis to be made by any competent gynaecologist.

Treatment.—Where the ovarian hernia takes place through either of the abdominal rings or downwards into Douglas' space, it may in some instances be reduced, as any other hernia in similar situated. In the majority of cases, however, such herniae are irreducible when discovered, and must either be supported in the former case by applying a hollow truss, whilst in the latter case the prolapsed ovary must be replaced if possible and kept in position with a peculiar form of pessary, exhibited and specially devised by Dr. More Madden for the purpose, or failing this, if the symptoms be urgent, the ovary must in some cases be removed.

The foregoing views are illustrated in the paper of which this is an abstract by the details of several instances of ovarian herniae, exemplifying the clinical history and treatment of such cases.

Society Reports.

MEDICAL AND SURGICAL SOCIETY OF BALTIMORE.

STATED MEETING HELD MARCH 13TH, 1890.

The 708th regular meeting of the Society was called to order, with the President, Dr. H. T. Reynolds in the chair.

Dr. Randolph Winslow exhibited several specimens illustrative of

INFLAMMATORY DISEASES OF THE UTERINE APPENDAGES.

He said he thought this a good subject to discuss in a Baltimore medical society, as Baltimore was a stronghold of the idea of pelvic cellulitis. He had only recently gotten his mind clear of this idea. He had been taught that the symptoms of pelvic cellulitis was fever, chill, pain in the pelvis, and a feeling or condition of board-like hardness in the pelvis. As a result of gonorrhœa, a female may present these symptoms, the inflammation may travel up from the vagina to the uterus, to the tubes and thus set up a salpingitis. This is a condition rarely recovered from, and is most likely caused by gonorrhœa. It is easy to see how an inflammation may be set up by the introduction of dirty instruments or unclean hands, and it may be accepted as proven that pelvic cellulitis does not occur primarily, but is secondary. A pus-tube may burst and produce a general peritonitis or a local peritonitis with the agglutination of the surrounding parts.

The first specimen is a pus-tube. This case was treated by a prominent gynaecologist as a case of pelvic cellulitis. Dr. Winslow said he thought the primary cause was a gonorrhœa. She finally fell under his care, and having gotten rid of the idea of pelvic cellulitis, he looked for another cause as the source of her trouble. Pus-tube was diagnosed and an operation was performed. The patient was 29 years of age. She made a good recovery and has no trouble now, except the flushings of the menopause. It was operated on in May 1889, and he thought it was the first case recognized and operated on in Baltimore.

The second specimen is a hydrosalpinx. Patient 27 years old. She was the abandoned wife of a sporting man. She had a profuse discharge. She could not work, she had pain, nausea, and was generally broken up. After an examination she was compelled to keep her bed for several days. The outcry of unsexing a woman in this condition is without foundation; they are already unsexed, and it is impossible for them to bear children, as the specimen will show.

The third specimen is also hydrosalpinx. The tube is large with numerous cysts attached to it. This case had peritonitis, and gonorrhœa was the probable cause.

The fourth specimen is the same as the second and third. This case had a severe peritonitis, and all of them had numerous adhesions.

The fifth specimen is a pus-tube. In this case no gonorrhœa was suspected at first, but later developments point to that as the probable cause. She was 29 years old and gave the history of having "caught cold" four years before. She had peritonitis and was ill for weeks and weeks; finally she got out. This fall she fell under Dr. Winslow's care and she was operated upon, only one tube and ovary was removed and no trouble has followed. In answer to inquiries, Dr. Winslow said that the diagnosis was made in several of these cases by plainly feeling the pus-tubes. That he did not believe in a pelvic cellulitis except as a secondary affection. That sometimes the diagnosis can be made without an anæsthetic, but in those very sensitive cases spoken of, it is best to use an anæsthetic to make a positive diagnosis.

Dr. J. W. Chambers said that operation was the only proper thing to do in cases where the condition is recognized, and where one is in doubt, he thought it justifiable to cut down and explore. He did not agree with Dr. Winslow in that a hydrosalpinx could be caused by gonorrhœa. If a salpingitis is caused by a gonorrhœa, he thought it should be a pyosalpinx and not a hydrosalpinx. He thought it quite possible that some cases of women suffering from acute pelvic cellulitis, or peritonitis, or salpingitis, do recover and that without operation. If they do recover, the organs then function properly, and they then bear children. He congratulated Dr. Winslow on exhibiting so many pathological specimens. The specimens are pathological, not from a gynaecological, but from a pathological standpoint.

Dr. F. C. Bressler said he thought it

dubious as to a pelvic cellulitis being always a secondary affection. If it be secondary, why is it not bilateral instead of unilateral as it usually is. He had a case of pelvic cellulitis following an abortion. He thought he was the cause of the attack. In washing out the uterus with an antiseptic solution, he must have gotten some of the water in the tubes, for the patient immediately became collapsed. Now, when is the time to operate on a case of this kind? All inflammations can spread by contiguity as well as by continuity, and we may have these conditions set up by injuries following abortion or by the use of instruments. He asked if Dr. Winslow had ever tried massage as recommended by Brandt?

Dr. Winslow said in conclusion, of course we may have an abscess or an acute phlegmon in the pelvis as well as anywhere else. In pyosalpinx the fimbriated extremity becomes occluded. We may have cases of peritonitis that are recovered from, but when you recognize a pyosalpinx, he thought only one thing was to be done and that was to operate. You cannot have a salpingitis without some peritonitis. The acute cases are to be treated by hot fomentations, rest and opiates or salines, but he was not discussing acute cases, it is in chronic inflammatory troubles that he advises operation. As to Brandt's method of massage and friction, he had not tried it and never would. He thought it too much like masturbation.

Dr. J. W. Chambers exhibited a specimen of

MULTIPLE ENCHONDROMA.

He said the specimen was interesting because of its large size. No reasonable person would have allowed it to grow so long. It began as a painless, gradual enlargement of the thumb of the left hand at 10 years of age, and had it been cut down upon and enucleated just as though it were a sequestrum, his hand might have been saved, but it was al-

lowed to remain and grow to an enormous size until the patient was 44 years old, when the amputation was done.

Enchondroma is not malignant. According to Bryant and others, they are more apt to involve the phalanges of the upper and lower extremity. They may also occur in the clavicle, scapula, femur, parotid gland and testicle. The family history of the patient was good. The growth gave him no trouble until about a year or so ago it began to pain, when some of the cysts^o began to break down. These cysts contained the characteristic dark, bloody fluid.

Dr. Shertzer said about two weeks ago he had operated on two, in the hands of a lady. They were central, not periosteal. He laid them open freely and scraped them out. She is doing well.

J. WM. FUNCK, M. D.,
Recording and Reporting Secretary,
1710 West Fayette street.

TREATMENT OF ECZEMA.

According to Pick, in a recent paper before the German Dermatological Society (*Medizinische-chirurgische Rundschau*, July, 1890), the indications in the treatment of eczema are, first, protection of the skin from external irritants, and secondly, by means of antiseptics, prevention of local infection. In the earlier (dry), stages of the disease these indications are fulfilled by the use of sublimated gelatin prepared as follows:

B. Refined gelatin $7\frac{1}{2}$ drachms.
Distilled water, a sufficient quantity.

After standing for some hours this is heated until completely liquefied and is then evaporated to $2\frac{1}{2}$ ounces. Then add,

Glycerin $6\frac{1}{2}$ drachms.
Corrosive sublimate $\frac{3}{4}$ grain.

Before using, the gelatin must be

melted by gentle heat in a water-bath, and it should be applied with a soft brush.

For the moist and vesicular, as well as the chronic form with more or less thickening of the skin, a permanent application of salicylic acid and soap should be used. The following is the formula used by Pick:

R. Liquefied soap plaster $3\frac{1}{4}$ ounces.
Salicylic acid 75 grains.

M.—Spread on soft cloths.

This may be rendered more adhesive by the addition of olive oil, thus:

R. Liquefied soap plaster $2\frac{1}{2}$ ounces.
Olive oil 5 drachms.
Salicylic acid 37 grains.

The plaster should be cut in strips so that it may be closely applied to the diseased parts. If there is much secretion the plaster should be removed on the third or fourth day, but the subsequent dressings may remain in place eight days or longer. After the amount of secretion has been reduced, the sublimated gelatin may be used as in the dry form of the disease.—*Medical News*.

GURJUN OIL AS AN EXPECTORANT.

Dr. William Murrell, of London, England, has been trying gurjun balsam as an expectorant in cases of chronic bronchitis, and writes to the *Lancet* of May 3rd that he has thus found 2 drachms of the balsam in an ounce of extract of malt, given three times a day, to be the best form for using it. Compared with balsam of copaiba, it seems less apt to disturb the digestive organs and skin, and patients who had taken both spoke commendatorily of the former as clearing the chest and easing the cough.—*American Druggist*.

MARYLAND MEDICAL JOURNAL

Weekly Journal of Medicine and Surgery,

WILLIAM B. CANFIELD, A.M., M.D., Editor

Subscription \$3.00 per annum, payable in advance.

Contributions from practitioners in good standing invited, and advertisements from reliable houses solicited.

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No. 209 Park Avenue.**

BALTIMORE, MD

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BALTIMORE, AUGUST 16, 1890.

Editorial.

**THE TENTH INTERNATIONAL
MEDICAL CONGRESS
AT BERLIN.**

The International Medical Congress has closed its tenth annual session, and most, if not all of the visiting members, have left Berlin, it is to be hoped, with a favorable opinion of the great capital and the scientific medical work done in that country.

Membership cards were issued to 7,056, of which 623 were to Americans, 421 to Russians, 353 to British, and 173 to French physicians. Of course there were many unregistered physicians present, so that it is safe to estimate the attendance at about 10,000.

At the opening, after addresses by several State and City officials, Dr. Rudolf Virchow, President of the Congress, made the opening address. Other addresses of welcome were made, which were responded to for this country by Surgeon-General J. B. Hamilton and others.

The general sessions seem to have attracted the greatest number, and indeed the seating capacity in many of the halls was taxed to its utmost.

The result of this congress is probably satisfactory, especially to those who were familiar with the three official languages.

Papers of great merit were read by European physicians and surgeons, while the work of the Americans was well received and heartily criticized. Of course, what good will flow from such a meeting can only be counted after months and years. The general arrangement of the work seems to have been satisfactory. More papers were announced than could be read, and these were omitted. America was well represented by men whose work made an impression, and in view of their low estimate of our medical educational system, this was very timely.

The social feature of the congress was not omitted, and the delegates with their families had ample opportunities to test the hospitality of the Germans.

On the whole, the members are to be congratulated, for out of the enormous number of papers, many unread, some will make more than a passing impression on the medical world.

**THE RELATION OF ACETONUTRIA
TO DIABETIC COMA.**

It is well known that many cases of diabetes mellitus terminate in coma. Investigations in regard to the immediate

cause of this coma, had resulted in the announcement that acetone was present in the blood of such comatose patients and was the septic agent by which the coma was produced. More recent investigations, however, cast a doubt upon these statements.

In the *London "Medico-Chirurgical Transactions,"* Vol. 72, 1889, p. 92, Dr. West discusses at length the whole subject, and adds the results of his own experiments and observations. He shows that acetone is frequently present in the urine of patients who are not diabetic and not comatose—in pneumonia, in cirrhosis of the liver, etc. Fourteen cases of true diabetes mellitus were observed and two cases in which glycosuria was temporary. Four of these died in coma, only one having evidences of acetonuria. A fifth died of septicæmia, not comatose, and afforded certain evidence of acetonuria. So it is evident that there may be diabetic coma without acetonuria, and acetonuria without diabetic coma. Moreover, the amount of acetone present does not vary according to the health of the patient or the amount of sugar in the urine. Thus, in one case the reactions for acetone were at first slightly marked, then very intense, then very faint for a few days and afterward quite intense again, the patient all the while steadily improving in health and finally leaving hospital while the reaction still continued.

In another case where a patient was dying with panting dyspnœa but not comatose, the urine contained little or no acetone, although the room, and in fact the whole house, was strongly scented with the odor generally ascribed to acetone.

The inference which Dr. West draws

is that *acetonuria does not stand in any definite relation to diabetic coma.*

It is, however, true that the evidence of the presence of acetone, and more especially the exhibition of the iron reaction, is a hint that the patient is more ill than when they are not obtained.

The iron reaction is rarely found except in cases of diabetes mellitus, but no connection can be traced between its presence and the occurrence of coma, and the test is often given in the absence of acetone. The test is likely to be obtained in any case where the patient has been subjected to excitement, worry or fatigue, and it is known that such influences tend also under certain conditions to produce coma.

Correspondence.

LONDON LETTER.

HOTEL LIFE—WOMEN—DR. BANTOCK—
THE ANÆSTHETIC PREFERRED—CLEANLINESS VS. ANTISEPTICS—THE NEW SAMARITAN HOSPITAL—MR. KNOWSLEY THORNTON — DR. WM. ORD — THE “UNITED HOSPITAL ASSOCIATION” DINNER—APOSTOLI’S CLINIC.

LONDON, July 14, 1890.

Editor Maryland Medical Journal :

DEAR SIR:—I wrote you from London, but had no time to speak of our doings in that wonderful city. We had written to the Metropole Hotel, from Liverpool, for rooms, before we went to Scotland, but on reaching there they had not one room to give us. We applied at the Victoria, the Grand and Morley’s; they were all full to overflowing. We then went to the First Avenue² Hotel, where

we barely got in on the fifth floor. I may say that this is the most comfortable hotel I have met with in London; but the Metropole is the place to be in the midst of the world and whirl, and as we were off to see and learn, we returned there next morning. Here all is grandeur and display, jam and cram. Here you are known by the number of your room, and not by your name. My room was 706, and I was known, not as Dr. Wilson, but as 706.—Complimentary to our vanity.

It is distinguished for gilt, trimmings and display, but particularly for its elegantly dressed women. The dresses were remarkable for their shortness at the top and length at the bottom—for very little dress above the waist and a great deal below it, with none on the arms. A huge bouquet, carried in the hand, protected the chest when occasion required. You are a gallant man, and interested in all that pertains to ladies, and hence these items. What would this world be worth without the women in it?

Dr. Chisolm and I went in different directions a part of each day in pursuit of knowledge, but we were always together by far the greater part of every day in diligent search for pleasure; and I may say here that he has the best pair of legs under him I have ever seen, as I have frequently known to my sorrow. He was all Eye, and away he went to one hospital. I had more of a fellow feeling, and off I went to another, but always to meet him at a given time and place.

Although I saw other medical men, I was particularly fond of being with Dr. Bantock; first, because I never saw his superior as an operator, and, second, because he is a noble, generous, whole-soul man. He is always willing and ready to impart his knowledge, of which he has a never-failing fund, in all that pertains to abdominal surgery. He is pre-eminently noted for his kind attention to Americans, always glad to see them at his operations and welcome them under his hospitable roof.

I saw him do three laparotomies, all

very difficult, but the ease and skill of his manipulations, and his resources to overcome difficulties as they arose, were charming. He does not believe that the dangers to a patient are increased by the presence of a number of persons. I never saw him operate at the hospital with less than twelve or fifteen persons present, usually in a small room, with rather low ceilings. He does not use antiseptics of any kind or description—simply hot water—but he is scrupulously neat at every step of the operation. The neatness of his person and dress, even to that ever-present button-hole bouquet, is strikingly reflected in his abdominal surgery. He washes out a great deal; he is a firm believer in drainage tubes. When in doubt, he says: "Always put one in." No one has better results.

I have seen the work of four of the best operators in England. None of them use any antiseptics; none of them exclude any number of persons from their operations. All of them use chloroform but one, and he uses chloroform and ether. In not a single instance, in the whole of Europe, have I ever seen ether used. Nothing but chloroform, except once, and then chloroform and ether.

From my observations in Europe, from my own experience in recent years, I am satisfied that it is not antiseptics, which secure success in abdominal surgery, but careful manipulation, punctilious cleanliness, washing out when necessary, and the drainage tube.

All this parade of changing dress in the attendants before an operation; scrubbing out the walls and floor of the operating room with antiseptics, etc., may do very well to make an impression upon the public, but strict cleanliness about the patient, and strict cleanliness in the operator and his assistants, is all that is necessary to success in the hands of a skilful operator.

The Trustees of the old Samaritan Hospital have built a new Samaritan Hospital on the Marylebone road, London. Dr. Bantock kindly took me through it, from the kitchen to the attic. It is com-

plete in all its appointments, has all modern improvements, and is a model of its kind. It will be opened early in October.

Mr. Knowsley Thornton has resigned his position as surgeon to the Samaritan Hospital. Dr. Bantock does his first operation in the new hospital early in October.

To Dr. Wm. Ord (whom, with his charming daughters, I had the pleasure of entertaining at my country home, "Idlehigh," a few years ago), I was indebted for an invitation to dinner at the Crystal Palace, given by the "United Hospital Association." I went as his guest.

This is an association of twenty-four members, formed from the staffs and internes of St. Thomas' and the Old Guy's Hospitals. Years ago there were difficulties between these gentlemen, which led to estrangement, and this Association was formed to restore and promote good feeling between them. Vacancies rarely occur, except by death, and there are always many names up for election to the first vacancy.

Each member subscribes £20 a year, and pays twenty-five shillings for each person whom he takes as his guest. They have four dinners a year. About thirty-four persons sat down to dinner—members and guests. The dinner was elegant, the wine excellent, and of every quantity and variety. Sir Wm. MacCor-mac, Mr. A. Durham, and other distinguished men. (whom we know so well in America), were present. The champagne was in immense bottles, from two to three quarts in each, the former called Magnums and the latter Jeroboams. I had a charming evening till the chairman arose at the end of the dinner, and said, that only two toasts would be proposed. The first was the "Queen," which was drunk with a hearty good will. Everything was then quiet for about ten minutes, and I was beginning to feel very comfortable, when he again arose and proposed "the health of our invited guests," and called upon me to respond. I hope sir, that you will never have such

feelings as I had at that moment; but I had been basking in the shade of Magnums, and drinking refreshing draughts from Jeroboams, until it would have been criminal to hold my tongue. Even the dumb Ass would have opened his mouth under such circumstances. I made the speech, to the apparent satisfaction of my most immediate friends.

This letter is already too long, but I must tell you what profit and pleasure I have had in attending the clinics of Dr. Apostoli. He holds them at No. 19 Rue de Jour every Tuesday, Thursday and Saturday afternoons from 3 to 5. His waiting rooms are filled with patients, and his examination room is crowded with medical men and women of all ages, and from all countries.

He was exceedingly cordial and attentive to me, called on me to examine every patient that entered, and confirm or reject his diagnosis,—explained to me his methods, and appliances, in the use of electricity. This is my second visit to him; and the more I see of his practice, the more I am satisfied that the reason so many men do not get his good results, is because they do not *minutely* follow his directions in every particular. He is perfectly honest in his convictions, and perfectly truthful in his statements.

From my own experience and from what I have seen of Dr. Apostoli's practice, I am satisfied that electricity administered with caution and judgment, is a powerful and efficient remedy in many forms of chronic pelvic disorders.

Dr. Apostoli gave me a handsome breakfast, and showed me many other acts of kindness, for which I feel under many obligations.

I could say much more, but must stop. You shall hear from me at Munich.

Faithfully Yours,
H. P. C. WILSON, M. D.

Dr. Isidore Labatut, who died recently in New Orleans, is said to have been the oldest physician in the United States. He was born in April, 1793.

Miscellany.**PROFESSIONAL APHORISMS.**

Nothing is to be disdained in order to acquire and preserve a *clientèle*. A physician I have long known, a man of good sense, fine taste and much experience, said to me one day: "My commencement at practice was very fortunate. I had for years the best class of patients in my neighborhood, but little by little my business fell off, and Dr. H., a neighbor, succeeded in taking my most profitable families. H. was not a bad fellow, and employed no disloyal methods to undermine me. Meantime, he had neither talent nor the good address I possessed. I racked my brain to discover the cause of professional discomfiture, when one of my best patients, a jolly young girl, remarked to me one day: "Why don't you do like Dr. H? I will tell you why you are losing your grasp on the neighborhood. H. wears immaculate white linen and always looks like he came out of a bandbox. The majority of well-bred people like a neat and clean physician." I took the hint and soon recovered my lost vantage. So much for a physician's clothing.

Many physicians neglect their toilette, and the world is more exacting on this point than is generally believed. Ninety-nine-hundredths of the public think the habit makes the monk. A doctor who wears a green coat, blue pantaloons and a white vest with a yellow necktie, shocks good taste by this grotesque assemblage of coloring. Only Dupuytren was able to do this. A large brimmed hat, large cloak and small boots, are only supported by the reputation of Antoine Dubois. Portal was a genius whose clothing of a previous age passed on account of his celebrity alone. But all eccentricities in costume cost the mass of the profession dear. With equal and even inferior talent, the physician properly habited has every advantage over the negligently attired doctor. "My dear sir, when will you get a new suit of clothes?" asked the Marechale de Luxemburg of Bouvard.

"When I meet an honest tailor," answered the physician brutally. The lady dismissed Bouvard and employed Borden, whose beautiful attire attracted all Court ladies.

A very celebrated physician, one who attached no importance to his attire, presumed in an independent fashion to go to dinner at a Prime Minister's in a sack coat. Arriving at the palace he was met by the lacquay in waiting who prevented his entrance. "What do you mean, impertinent!" demanded the physician. "That Monsieur should remove his sack coat," replied the irate lacquay. "Do you want me to enter in my shirt!" exclaimed the unwelcome guest. "Go, rascal! tell your master that Dr. F., member of the Academy of France, has come to dine with him without a full dress suit." This was more cynical than pleasant for the host, and an insult to the guests.

A propos of costume, there exists a decree of November 12, 1803, which has never been repealed in France. The law for the regulation of physician's attire reads: "Ordinary practitioners of medicine, when invited to public assemblages, and when summoned before tribunals of justice, are ordered to wear the following costume: a black cloth robe lined with common silk, an ermine border, a black dress suit with a white linen cravat, and a cap of red silk with a gold border."

A physician's office demands attention, especially in large cities. It is here the *mise en scène* is perfectly legitimate. In the district you select make choice of as large a house as is possible to obtain for your money. A coach-way, fine staircase, and a waiter at the door, will almost pay an enterprising practitioner. Inform yourself as to the rank, worth, and influence of your various neighbors, and above all post yourself as to how your nearest business rival, if he be successful, conducts his affairs. A fine office at the height of the building in an apartment house is the gauge, the infallible thermometer for the position of a Parisian doctor. The second floor is the *ne plus*

ultra of medical ascension. A third floor office with a small entrance evidences considerable impudence combined with enterprise, for three flights of stairs is a long distance for a patient to climb. Never mount as high as the servant's sky parlor.

A doctor should always have two rooms: a waiting apartment and a private office.

The waiting room should always be supplied with a very large velvet lounge. Have your other furniture neither covered by silk nor velvet, but by bright colored gingham; people will think those coverings are to protect material equal to that on your magnificent velvet covered sofa. Put up fine lace curtains, the handsomest material you can obtain. A woman's quick eye always takes the curtain as a general index of rich garniture, and will be satisfied with lace alone. Hide bare walls with two or three choice engravings, and if you have means, with meritorious work in oil or water colors, but do not buy that common, very common medical print of *Hippocrates refusing the gifts of Artaxerxes*; besides the fact being apocryphal, it sets a very bad example for practitioners to follow. A doctor of good taste is always recognized by his office clock. Have one with a neat bronze group on top. Have no piano or music rack in your reception room; people who are sick, or whose friends are ill, do not like to be reminded of the pleasures of life. People visiting a doctor's office are only impressed by two ideas: they seek pity or aid, and care nothing for amusements. A physician's office should always have two doors: one for entrance and one for exit. It has a decided influence on clients, who are probably willing to be seen entering an examination office, but desire to leave by a private door. See that your office servant is polite and neatly dressed. It is always best that it be a man. Maid-servants are to be avoided; they are apt to tattle. A patient should always be kept waiting for a few moments; it calms agitation and leads them to think that you have another client in your

private office. Always open and close the inside door of your private office, so as to leave the impression that you have just dismissed a patient from your inner sanctum. It is best also to rattle a few silver pieces of large size. This reminds the outside client that fees in cash are in order.

In consultation the great secret of success is to know how to listen; a patient always desires to unbosom himself to a medical confessor. Show me a good listener, and I will show you a man with a large practice. Be sympathetic and patient, giving the client's tongue full swing. Some will talk much, some but little. Do not interrupt a patient's conversation, as it will lead to prolixity; if he does not talk much make him repeat the most interesting details of his case. This produces a grand moral effect, and as good thinkers are often poor talkers, you will often be mistaken for a savant and highly esteemed by the patient. Be careful that no detail of the consultation shall turn to your disadvantage.

One of the most vigorous precepts of charity in medicine makes it imperious to console and reassure a patient, leading him to always hope for a cure, even though you know the malady to be incurable. Never make a slight affection appear slighter than it is. The doctor in slight illness should give positive assurance that he can cure the malady—in time. As a general rule a patient loves to persuade himself that he has been in great danger, and this compensates for the medical fees he pays. It is bad policy not to make a patient realize that he owes you something more than money can repay. Permit him to feel under personal obligations. If he thinks you saved him from death when he was really in no danger, do not tell him to the contrary. Avoid dangerous exclamations such as fall from the mouths of honest young practitioners in their first innocent verdancy, as for instance: "Ah! it's nothing. You are only a little indisposed. A little dieting will

remedy all. Don't take medicine when you do not need it." Physicians who are honest, or rather impolitic enough to tell the truth, are not money makers, nor are they esteemed by their clients. Most people who visit a doctor desire to be told that they are ill. To tell them the contrary is to make them out asses. Nine people out of ten who visit a doctor's office are but slightly indisposed, but tell them the truth and they will seek some other physician for consultation. The men with the largest practice are the patient listeners and greatest liars. These two things are prerequisites for success. A surgeon may be a talkative man and converse with his clients, but the brainless, silent and austere physician will beat the most brilliant conversationalist in the pecuniary emoluments of the profession.

Make it a point never to allow a patient to leave your office without a written prescription. It is also good policy to give your client written directions as to diet, etc. Don't be afraid to waste prescription paper on any patient. Fill in boldly the *recto* and the *verso*, and the client feels that he is getting his money's worth. The young doctor who says to the patient: "Never mind a prescription, Go to the pharmacist and get a dose of salts," is an ass who will learn better after a while. When you write *sulphate of magnesia* on paper, it reads better than the exclamation *salts*. Remember the rich client for whom Corvisart wrote no prescription, the banker who left ten centimes on the table in place of ten louis. He valued the doctor's services as highly as the doctor valued his intelligence. Yet Corvisart was, for a wonder, the Emperor's physician. Every large city has rich people, "*malades imaginaire*," who visit some doctor's office every day and pay good fees. Every time such a man comes around he has a new disease, and it is best to plunge him off the bridge of sighs in the proper direction. When any patient has received his prescription, rise in your chair, and bowing politely, open the exit door. Don't

permit him, however, to forget paying his fee.

Some patients will not follow their physician's prescription or instructions. What will you do under such circumstances? Will you humor these whims for the sake of the compensation, or will you assert your professional dignity and abandon the cure of the case? Only celebrated men can afford to assert their professional dignity. It will always happen that such patients can find an obliging doctor.

No doctor who lives should refuse to prescribe for a poor patient who enters his office. It costs nothing, and charity covers a multitude of physician's sins. Besides, no man, however obscure, lives, who has not one friend or some influence; at least there are few exceptions to this rule. Besides the poor belong to God, the rich to the devil. It is always well to have a little credit on the right side of the Heavenly balance sheet. Some physicians are ingrates and mean enough to neglect people who paid them money in their beginnings. Always help those who helped you when you were young, no matter how low in life your early benefactors may now be.

Some doctors demand a fee from a stranger before even examining him. This is an insult, and equivalent to "Your money or your life!" Always be polite in the matter of fees. Do like Alibert, who waited on a celebrated Cardinal who had forgotten to pay him on two previous visits: "Monseigneur," said Alibert smilingly, "You can use the three louis you now owe me to say masses for the conversion of forgetful sinners." The Cardinal understood the hint and opened his purse.

It sometimes happens that a patient honors a physician in some infamous manner and thus wounds professional dignity. Never accept small compensation for your services. You place the value on the goods, and are taken at your own self-estimation. Always have a fixed minimum fee and never go under it. Antoine Duboise always followed this

rule, and on one occasion he received only three five franc pieces instead of four. He allowed the money to fall on the floor and he and the patient sought for the coins. Three pieces were found and handed to Duboise. "There is another five francs missing," said the doctor, "We must find it!" And the patient took the hint and coolly found the unlost money.

LACTIC ACID TREATMENT OF DIARRHŒA.

Hayem has recently reported before the *Société Médicale des Hôpitaux* the success which has attended his employment of lactic acid in diarrhoea. He prescribes the acid in the dose of 2 drachms in the form of a lemonade, made as follows:

Lactic acid	2 drachms.
Simple syrup	½ ounce.
Water	3 ounces.

To be drunk during the intervals between meals.

Hayem thinks this particularly useful for the diarrhoea of typhoid fever, and in that form of lientery dependent upon *hypo-acidity* of the stomach. The same observer also recommends it as a cure, and prophylactic in epidemic cholera.—*Med. News.*

NEPHRITIS WITHOUT ALBUMINURIA.

Billaux (*Journal des sciences médicales de Lille*, 20 décembre, 1889), concludes his article as follows:

1. Albuminuria is only one symptom of chronic nephritis, and, like all symptoms, may be temporarily or permanently absent.

2. The excretion of albumin in chronic Bright's disease is an important symptom, and should lead the practitioner to subject the urine to repeated examinations.

3. Albuminuria is especially apt to be absent during the uræmic attacks.

4. Certain ulcers of the stomach and

duodenum are only accidents of the arterial sclerosis of chronic nephritis. It is therefore of importance in haemorrhages from the digestive tract to search for evidence of Bright's disease.—*Annales des maladies des organes génito-urinaires*, février, 1890.—*Jour. of Cut. and Genito-Urinary Diseases.*

Medical Items.

Boys under sixteen found smoking cigarettes in New York are liable to arrest.

Dr. J. T. Councilman, a well-known practitioner of Pikesville, Md., died at the Johns Hopkins Hospital last week after an operation for typhilitis. He was 70 years old.

"Dr." A. Wilford Hall, whose tricks have been exposed in Philadelphia, is now turning his attention to Baltimore, a city where any quack may ply his trade without fear of punishment, thanks to our worthy governor.

The Cincinnati Lancet-Clinic, one of our most readable exchanges, in its issue of August 2nd, contains an editorial on "Nutrients" in praise of certain proprietary and patented medicines, and in the next issue decries the evils of subscribing to any but regular medical journals not published in the interests of proprietary medicines.

The American Rhinological Association will hold its Eighth Annual Session at Louisville, Ky., October 6th, 7th, 8th. All leading subjects relating to nasal and naso-pharyngeal diseases will be opened for discussion by a leading fellow of the Association. The medical profession is cordially invited to attend. The secretary, Dr. R. S. Knode, Omaha, Neb., will furnish any information to physicians desiring to become members.

MARYLAND MEDICAL JOURNAL.

VOL. XXIII. No. 17. BALTIMORE, AUGUST 23, 1890.

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THE DIAGNOSIS AND TREATMENT OF THE SIMPLER EYE DISEASES.

BY HERBERT HARLAN, A. M., M. D.,
OF BALTIMORE.

Assistant Surgeon Presbyterian Eye, Ear, and Throat Charity Hospital, etc.

In recent years there has been much discussion of the tendency to specialization in medicine, and general practitioners often complain that their field is yearly getting to be more and more limited. Like most questions, this one has two sides. Medical science is too big at present for any one man to know it all, and yet, if the family physician refuse all cases which properly are classified under one or the other specialties, it results in his field being comparatively a small one, and in his making a mere

medical directory of himself, a distributor of patronage to specialists.

There is a limit which should be well recognized. For instance, there are many diseases of the eye which should be referred at once to the oculist, and the family doctor who treats a case of glaucoma or beginning purulent ophthalmia under the impression that he is dealing with a "*cold in the eye*," is incurring a grave responsibility, and the blame for the so frequently occurring blindness in perfectly remediable diseases is surely to be laid at his door. On the other hand, there is a large class of cases that the general practitioner should be perfectly competent to recognize and treat successfully, and there is no reason why he should not do so.

It is with this class of cases that I propose to deal in these papers. Of course as in every other branch of medicine, the greatest difficulty lies in making the diagnosis, and when one does not know how to distinguish between a conjunctivitis

and an iritis, a pterygium and a cataract, in justice to himself and his patient, he ought to refer the case to some one who does.

The Examination of the Eye:—

In endeavoring to find out the cause of trouble in the eye of a complaining patient, it must be carefully looked at in a good light, preferably daylight, and the examination should be systematic. Let the lids first be inspected, then the condition of the cilia, puncta, conjunctiva, cornea, sclerotic, and iris, in regular rotation. In many cases, particularly with children, it is preferable not to touch the eyelids at all, and more can be seen without artificial separation of the lids. It seems a very simple matter to open the eyelids and look at an eye, but in fact it is a procedure requiring no little skill to enable the doctor to see thoroughly, and to do this without causing pain to the patient, and if the patient is made to suffer there is a gush of tears and the lids close in spite of the best efforts of both parties to keep them open. When necessary to separate the lids, it is best done by using the thumbs of the operator, and in such a way that all needful pressure is made against the frontal bone above, and the superior maxillary below. No pressure is to be on the eyeball itself. In this way the most painful eye may be examined without discomfort further than that caused by exposure to light.

I would lay particular stress on the importance in examining an eye, of noting carefully the condition of the lids, cilia, puncta, conjunctiva, cornea, sclerotic, and iris, separately, and in some regular rotation. Long practice enables the specialist to see all these at a glance and without being conscious of the minute details of an inspection which seems quite superficial.

Before taking up the diseases in detail a single word in general about treatment. I shall endeavor to confine myself to as few remedies as possible, and will mention those which have given the greatest satisfaction in my own experience.

Diseases of the Eyelids; Styes.—

A stye is an acute inflammation of the nature of a furuncle of the cellular tissue along the edge of the eyelid. It generally starts about the root of the hair follicle, and can often be abated by pulling out the eyelash, about which the inflammation seems localized. A diagnostic point is the inflamed spot at the margin of the lid, and the treatment consists in evacuating the pus after it has formed. Like boils elsewhere, styes often appear in successive crops, and I believe in these cases more frequently as a result of direct inoculation of the hair and skin follicles by matter from the first styes, than from any peculiar constitutional condition. In such cases the eyelids should be kept scrupulously clean, by frequent applications of antiseptic washes or ointments, preferably the former. It is well also to put the patient on a course of tonics.

Blepharitis.

Next to styes, the most frequent trouble found with the eyelids is tinea tarsi, or blepharitis marginalis. This is an inflammation of the nature of an eczema of the margin of the lids, and appears with wide variations of intensity from a slight irritation and scaliness to a great deal of redness and swelling, and the formation of thick crusts and pustules about the roots of the hairs. The lids are frequently matted and stuck together in the morning, and it is with difficulty they can be separated. The disease occurs most frequently in children, especially among those of a strumous diathesis, and in more severe forms, often causes more or less complete destruction of the eyelashes.

The milder forms are often caused by neglected errors of refraction. The more severe ones are probably never due to this cause, but arise in the course of a phlyctenular or catarrhal conjunctivitis. The treatment consists in first thoroughly removing all the crusts and scales and then in the application of an ointment of the yellow oxide of mercury (gr. ii to 3 i). When the scabs or crusts

are very thick and hard, they can easily be softened by some alkaline wash as sod. bicarb. gr. x to warm water $\frac{3}{4}$ i. As some of the ointment, when thoroughly applied is sure to get into the eye, it is very important that it be carefully made. Carelessly made, it contains small particles of the mercuric salt, and is very irritating to the delicate mucous membrane of the eye. When smooth and thoroughly rubbed up by the druggist, it causes no irritation whatever. Of course when errors of refraction are present they should be corrected by suitable glasses. The above treatment will be found quite satisfactory, but in chronic cases the application of the ointment must be continued for quite a long time.

Meibomian cysts, or *Tumor tarsi*,—are often caused by blepharitis and are small cysts forming in the course of the duct or the Meibomian glands themselves. They appear as little lumps about the size of a pea and should be incised, and the contents scraped out with a small curette.

(To be continued).

DISEASES OF THE PUERPERAL PERIOD. SAPRÆMIA.*

BY WILLIAM S. GARDNER M. D.

Lecturer on Obstetrics, College of Physicians and Surgeons.

Gentlemen;—I wish to call especial attention to sapræmia during the puerperal period; because it is the most common of the septic diseases subsequent to parturition; because it is so commonly confused with septic infection; and because of its curability. While it is true that there are some resemblances, both in etiology, and symptomatology, existing between sapræmia or septic intoxication, and septicemia or septic infection, still there are wide differences and many points by which they may be distinguished from each other. And this distinction should, and must be made. He can not

be held guiltless who plies his patient with opium and antipyretics and allows her to die with a decomposing clot in her uterus.

Before taking up the etiology of sapræmia I will read the notes of a number of cases which have fallen under my care. I will go into these details not because the subject is difficult to comprehend, but because it is of great importance to be familiar both with the condition present in this disease, and with the rational treatment of it.

CASE 1063.—Aged 19, white, primipara, was confined January 9, 1886. The duration of the first stage of labor was fifteen hours; the second, two hours; the third, twenty minutes. During the first, second and third days the temperature did not rise above 99°; the pulse ranged from 68 to 88.

The fourth day, at 9 A. M., the temperature was 99°, the pulse 80. Late in the afternoon she had a severe chill. At 7 P. M., the temperature was 104.5°, the pulse 140, and weak. The skin was cool. The uterus could not be outlined, and was supposed to be relaxed, as it actually was, as shown by subsequent examination. There was no pain over any portion of the abdomen or pelvis. Antipyrine, ergot and vaginal injections were used.

The fifth day, at 9 A. M., the temperature was 102.5°, the pulse 124. Same treatment was continued. Throughout the day the patient was somnolent. She could easily be roused, but dropped to sleep immediately upon being left undisturbed. At 7 P. M., the temperature was 104.5°, pulse 140. As shown by the chart, antipyrine in fifteen-grain doses failed to reduce the tempeature. Late in the evening the uterus was washed out with a solution of mercuric chloride, after which fifteen grains of antipyrine promptly reduced the temperature to 100°.

The sixth day, at 9 A. M., the temperature was 101.5°, the pulse 120. Though the antipyrine and vaginal injections were continued, as the day ad-

*Saturday Lecture delivered at the College.

vanced the temperature continued to rise.

To furnish complete drainage, I took about a yard of common white rubber drainage-tube, and cut a number of openings in the three inches nearest one end. Then inserting the plain end into a large bottle filled with a solution of corrosive sublimate, 1-4000, a stream of the solution was started through the tube, and while the stream was running, the cut end of the tube was introduced into the uterus. The tube continuing to act as a siphon, the uterus was washed out. The bottle was then nearly refilled with the solution of corrosive sublimate and suspended from the side of the bed. In this position the tube still acted as a siphon, but in the reverse direction, and effectually drained the uterus. Twice daily, while the tube remained in position, the uterus was siphoned out through it.

The seventh day the highest temperature was 102.5°. The eighth and ninth days the highest temperature was 101.5°.

These four days, with the drainage-tube in, the temperature was easily controlled by antipyrine.

The tenth day, at 9 A. M., the temperature was 98°, the pulse 96. The drainage-tube was removed, and no antipyrine was given after 6 A. M. At 7 P. M., the temperature was 103°, the pulse 124.

The eleventh day the uterus was washed out, the drainage-tube replaced, and no antipyrine given after 6 A. M. At 9 A. M., the temperature was 99°; at 6 P. M., it was 101°: showing a rise of two degrees during the day with the drainage-tube in, as compared with a rise of five degrees the previous day, when the tube was out.

Twelfth day, highest temperature 101°; thirteenth day, highest temperature 99.5°. The patient was bright and cheerful. The milk which had been entirely suppressed began to return to the breasts. The tube came out accidentally, but as there was such marked improvement in the patient's condition, its further usefulness was doubtful, and it was allowed to remain out.

The fourteenth day, at 9 A. M., the temperature was 99.5°; and at 7 P. M., it was 103°, pulse 128.

The fifteenth and sixteenth days the tube was kept in and no antipyrine given. The highest temperature was 102.5°.

The seventeenth day antipyrine was given, and the temperature did not rise above 101°.

The eighteenth day, at 9 A. M., temperature 101°; at 7 P. M., 102°. The tube accidentally came out, but as the temperature during this day and the nineteenth and twentieth was easily reduced by antipyrine, it was thought that surely from this time forward the drainage-tube could be dispensed with.

The twentieth day, at 7 P. M., the temperature was 102.5°; at 10 P. M., it was 105°, pulse 124.

The twenty-first day, at 9 A. M., temperature 105°, pulse 132. Antipyrine in twenty grain doses, repeated every three hours, failed to reduce the temperature. Again the tube was introduced, and the same effect noted as before. The temperature was at once easily controlled by fifteen-grain doses of antipyrine.

The twenty-second and twenty-third days, the highest temperature was 102.5°.

The twenty-fourth, twenty fifth and twenty-sixth days, no antipyrine was given. The highest temperature was 101°. The tube was removed permanently.

The uterus was washed out twice daily through a soft rubber catheter, until the thirty-third day. The last antipyrine was given the thirtieth day.

The thirty-third and thirty-fourth days the uterus was washed out only once each day, and then the intra-uterine injections were discontinued. The temperature remained slightly above normal until the forty-first day.

CASE 1078.—Colored, aged 17, primipara, was confined January 22, 1886. The duration of the first stage of labor was fourteen hours; the second, one hour and fifteen minutes; the third, twenty minutes. On the evening of the second day the lochial discharge was fe-

tid; the uterus relaxed; no pain over the abdomen; the milk not flowing. The temperature was 102°, the pulse 116.

Third day, at 9 A. M., temperature 102.5°, pulse 112. The uterus was washed out. Ergot was given. At 4 P. M., the temperature was 99°, the pulse 68.

Fourth day, 9 A. M., temperature 98.5°, pulse 84. At 7 P. M., the temperature was 101.5°, the pulse 104. The ergot was continued. The highest temperature after this was 100.5°. No antipyrine was given. The patient was out of bed the sixteenth day.

CASE 1306.—Aged 18, colored, primipara, was confined October 8, 1887. She was delivered by forceps of a child weighing nine pounds. There was considerable post-partum haemorrhage, which was checked by the intra-uterine injection of hot water. The patient was weak, but otherwise there were no unfavorable symptoms until the evening of the third day, when the respiration was 36, pulse 120, temperature 102°. A vaginal injection brought away several blood clots.

The morning of the fourth day the respiration was 34, pulse 142, and temperature 104°. The uterus was soft, relaxed and extended to the umbilicus. There was no pain or tenderness; the milk was suppressed; the lochial discharge was quite offensive to the smell. An intra-uterine injection brought away a large quantity of dark-colored, offensively smelling blood-clots. Ergot was given to contract the uterus.

The fifth day ergot, antipyrine and vaginal injections were used. The sixth day another intra-uterine injection was given. The matter washed out at this time was smaller in quantity and much less offensive than that of two days before.

After this she was given vaginal injections and an occasional antipyretic; but there was nothing of special interest during her convalescence.

Immediate Causes of Sapræmia.—In sапрæmia we have certain micro-organism

acting upon retained portions of placenta, membranes, blood-clots or lochia; the decomposition of the matter retained and the absorption into the system of the products of this decomposition. Concerning these statements three pertinent questions may be asked: First, what is the evidence of the presence of micro-organisms? Second, what is known of the chemical nature of the compounds formed by the action of these micro-organisms? Third, what is known of the poisonous effects of these compounds?

The evidence of the presence of micro-organisms is abundant, and is either direct or indirect. Directly, they have been found by all observers who have examined decomposing animal matter microscopically. Indirectly, by establishing the fact of the presence of putrefaction. The simplest definition of putrefaction is the decomposition of albumen compounds under the influence of moisture, warmth and certain micro-organisms. The albuminoids present may be in the form of placenta, membranes, blood-clots, or lochia. The two conditions of warmth and moisture are always present in the living body; so that the very fact of putrefaction is positive evidence of the presence of micro-organisms. The putrefaction can in many cases be discovered by the odor of the hydrosulphuric acid and ammonia compounds evolved. And I hope to be able, further on, to show that the toxicological effects of some of the -amines and -amides produced during putrefaction are of themselves evidence of the albuminoid decomposition.

Much labor has been expended by Brieger, Gautier, Vaughan, Pauchet, Scheurlen, Grawitz and many others in studying the compounds formed during putrefaction. It is true that the compounds formed during the first few days of putrefaction have not been worked up so carefully as the ones occurring later in the process. But enough is known to show that certain alkaloid compounds are formed at all stages, and that these animal alkaloids or ptomaines differ ac-

cording to the micro-organisms present and the length of time the process goes on.

A short sketch of a few of the best known of the ptomaines will probably help to clear up the subject.

For example, cadaverine, $C_5H_{14}N_2$, has been obtained by Brieger from human hearts, livers and lungs which had been left to putrefy in a warm place for three days. It seems to be constantly produced by the growth of the comma bacillus, without reference to the particular soil. The investigations of Scheurlen, Grätz and others show that cadaverine is capable of producing inflammation and necrosis.

Gautier and Etard obtained a base $C_8H_{18}N$ from the decomposing flesh of the horse and ox. They consider it a constant product of putrefaction. It is an alkaline, almost colorless, oily, liquid, and possesses a strong, penetrating odor. A dose of .0017 gram. injected under the skin of a bird produced marked unsteadiness of gait, paralysis, and finally death. The pupils were normal and the heart stopped in diastole.

Vaughan says of mydaline, another of these bases, that it "has an entirely specific action. Small quantities injected into guinea-pigs or rabbits produce, after a short time, moistening of the under lip, and an abundant flow of secretion from the nose and eyes. The pupils dilate gradually to the maximum, and become reactionless; the ear-vessels become strongly injected and the body temperature rises 1° to 2°. During the action of the poison the animal shows a tendency to sleep, and peristaltic action of the intestines is heightened. Larger doses induce an exceedingly violent action, which invariably results in death. On post-mortem examination, the heart is found stopped in diastole, and the intestines and bladder contracted; otherwise nothing abnormal is observed."

Ptomaines and their salts, like other bodies of a similar chemical nature, readily pass through animal membranes. This fact explains their ready absorption

from any cavity containing them into the system.

It is not claimed that cadaverine or mydaline, or any special ptomaine is the cause of the symptoms of sapræmia, but that the process going on in the parturient canal in this disease being identical with that which produces these ptomaines, it is certainly fair to presume that similar compounds are there produced, and that the symptoms are due to the effect of these ptomaines on the body after they have been absorbed.

Symptoms of Sapræmia:—

The symptoms of sapræmia come on after the end of the second day, and as a rule, before the fifth; near the end of the third day being the most common time. There may or may not be a chill. When there is a chill it is usually not followed by others. The temperature rises at once, often to 105°, and in nearly all cases above 103°. The pulse is rapid, varying from 100 to 140 per minute; the respiration is 30 to 40, or even more, per minute. For some days there is maintained a certain relation between the pulse, temperature and respiration. Any agent that reduces the temperature also reduces the respiration and pulse rate. The temperature does not follow any regular diurnal change, but fluctuates greatly. The possibility of drainage affects the temperature more than anything else. The condition of the skin is not constant; in some cases it remains cool, in others it is hot and dry, and in still others, though rarely, there is considerable sweating.

In some cases the brain does not seem to be affected, but in many, with the higher temperature there is somnolence. One patient under my care would sleep continually. She could be roused without much difficulty, and when awakened her mind seemed perfectly clear, but she dropped to sleep immediately upon being left undisturbed.

The uterus is large, so flabby that it is difficult to outline through the abdominal walls, and extends to or above the umbilicus. It is not painful on pressure.

The intestines often become distended, causing tympanites, but there is no pain or tenderness in any part of the abdominal or pelvic cavities.

In most cases the lochia has an odor of putrefaction. The absence of this sign should not be looked upon as precluding *sapræmia*. When it is marked it is of very great importance, but there are many cases in which the odor, if any, is so faint that it will escape detection. This is especially the case where antiseptic vaginal douches have been used.

In cases in which the milk-flow has been established before the beginning of the fever, it is suppressed. In cases where the fever begins before the milk flow, the flow does not begin at the usual time. In a majority of the cases the milk-flow is again established after the recovery of the patient.

Contagiousness of Sapræmia:—

It is claimed by the majority of writers that what is called the "autogenetic form of puerperal fever," by which misnomer puerperal *sapræmia* is sometimes known, cannot be communicated from one patient to another. Dr. Barnes says: "The autogenetic forms proper did not appear to possess the active powers of propagation. For example, a common form, that which arose from a decomposition of the placenta setting up a septicæmic fever, generally began and ended in the person attacked."

Dr. Fordyce Barker quotes the above and adds: "On this point my own experience and observations are in entire accord with Dr. Barnes." Galabin says: "Where there is septic intoxication or *sapræmia* only, without infection, there can be no contagion."

While we have good reason for believing that *sapræmia* is not contagious to the degree that septicæmia is, still it should not be forgotten that we have going on a morbid process, due to the presence of micro-organisms, and that the introduction of these micro-organisms into a suitable nidus will certainly set up a similar process.

Pathological Anatomy, Sapræmia:— On post-mortem examination, there are

found in patients dying from puerperal *sapræmia* only such lesions as are due to continued high temperature. Rigor mortis is usually very feebly marked. The blood is imperfectly coagulated; the heart is flabby and marked with petechiae beneath the pericardium; the liver and kidneys are congested and softened; there is always hypostatic congestion of the lungs; the spleen is large, soft and at times almost diffused, the mucous membrane of the alimentary canal is soft and swollen; microscopically, the heart, liver and kidneys are found to have undergone fatty degeneration. Welch has shown experimentally that these degenerations take place under the influence of high temperature, without the addition of any other agent.

Prognosis:— The duration of puerperal *sapræmia* is variable. It depends upon the condition of the patient at the time the disease is recognized; upon the anatomical relations of the pelvic organs in the individual, these relations having much to do with the drainage, and upon the treatment. Many cases will recover in a very few days; others, where there is much difficulty in keeping the uterine cavity cleansed, remain ill for days, or even weeks. Nothing can be said as to time; all that can be positively stated is, that under proper treatment every case will certainly recover.

Treatment of Sapræmia:— From the nature of *sapræmia* the treatment easily falls under four heads, and the only discussion is as to the best methods of obtaining the objects sought, which are:

- 1st. To cleanse the parturient canal.
 - 2nd. To secure tonic uterine contractions.
 - 3rd. To control temperature.
 - 4th. To support the patient.
- To keep the vulva and vagina properly cleansed is quite easily accomplished by external washes and vaginal injections. The vaginal injections are ordinarily some of the standard antiseptic solutions, preferably corrosive sublimate 1-5000. A vaginal injection should be given preparatory to all operations upon the uterine cavity.

The cleansing of the cavity of the uterus presents more difficulties and consequently more methods. On account of the comparative ease with which it can be accomplished, and on account of its efficiency, I place intra-uterine injections as the first and most important of these methods. I prefer for an intra-uterine wash solution of corrosive sublimate, about 1-5000. There have been a number of accidents from the use of corrosive sublimate in the parturient canal, but I think that nearly all, if not all, such accidents can be traced to some defect in the use of the solution. In a number of these cases the error has been in using an unnecessarily strong solution in large quantities, or there have not been sufficient precautions taken to insure the exit of all the fluid injected.

The syringe best adapted to intra-uterine injection is one made on the pattern of Davidson with the rectal nozzle on, and attached to this a soft rubber intra-uterine tube that I had made for the purpose. This tube is about twelve inches long and number seventeen (American), calibre. It is made of the same material as the soft rubber catheter. The point is smooth, round and closed. Three inches from the point is a slightly raised collar; between the point and collar, but grouped rather toward the point, are three large lateral, velvet-eyed openings. The whole instrument is smooth and flexible; there is not a rough edge that can scratch the most delicate surface. The open end of the tube is slipped over the nozzle of the syringe, and both are filled with the corrosive sublimate solution. The tube is introduced by grasping the point between the index and middle fingers of the right hand, allowing the remainder of the tube to rest in the palm of the hand; then carry the point up to the external os, reflect the point into the cervical canal, grasp the middle of the instrument between the thumb and finger of the left hand and gently push it in until the collar is felt at the os. You then know that the end of the tube is well into the

cavity of the uterus and still at a safe distance from the fundus. The solution is then forced into the uterus until it returns quite clear. About a quart is the quantity usually used, though as much as a gallon is sometimes necessary.

After the injection is finished, instead of removing the whole instrument at once, the nozzle is slipped out of the tube, the latter being left in place to insure the exit of *all* the injected fluid. When the tube comes out of itself it is placed in a 1-2000 corrosive sublimate solution till wanted.

I prefer the soft rubber injection tube for several reasons. It is much cheaper than the more complicated instruments; the flexibility allows it to adapt itself to whatever angle is formed by the vaginal and uterine passages; being soft and perfectly smooth it is not apt to break granulations, producing haemorrhage and making another possible route for septic infection. The stream of water passing through the small nozzle of the syringe, then through the enlarged and even calibre of the tube, out through several large openings, gives necessarily a gentle flow into the uterus. I do not believe it is possible to introduce a soft rubber tube through an os that is not sufficiently dilated to insure a return flow; hence risk of distension of the uterus is avoided. Where it is wished to keep up constant drainage, the same tube answers admirably. It can be made to retain its position by fastening the outer end with a piece of adhesive plaster to the thigh.

In some cases especially when there are retained bits of placenta, the douche fails to bring them away. In such cases the dull curette should be used, but not until the douche has failed. Put the woman in Sim's position and scrape out the entire uterine cavity, and follow the curette immediately by an intra-uterine injection.

Doléris has invented a sort of brush with which he swobs out the cavity of the uterus. The indications for its use are the same as for the douche or curette.

To secure contraction of the uterus, fif-

teen or twenty minimis of the fluid extract of ergot should be given every two hours. If the interval between doses be so long as four hours, the uterus relaxes and increases the opportunity for the accumulation and absorption of the products of decomposition. The same quantity of ergot does not act with equal power upon all cases and the dose must be varied until the amount is found which keeps the uterus firmly contracted.

The stomachs of some patients will not bear the fluid extract; in these cases the extract of ergotine may be used. Occasionally the hypodermatic syringe must be resorted to. I am in the habit of using the fluid extract subcutaneously. Put the needle its full length into the outer and lower side of the thigh and there is no need to fear abcesses.

When the temperatnre is not at once controlled by cleansing the cavity of the uterus, some antipyretic may be given, preferably antipyrine or antifebrine. Antipyrine should be used in fifteen grain doses, antifebrine in about half that quantity. No antipyretic should be given at stated times in stated doses, but the temperature should be watched carefully and a sufficient amount of the antipyretic given to keep the temperature below 102.5° F.

To promote drainage the patient should be raised to a sitting posture to attend to the calls of nature. At least a part of the time she should have her shoulders and back raised to a higher level than the hips, and at the earliest possible period she should be gotten out of bed.

Nutritious and easily digested foods should be given in as large quantity as the patient can be induced to take them. Milk given regularly every two hours is probably the most reliable aliment.

A statute of Henry VII, says an exchange, runs as follows:—The practice of the healing art should be limited to those persons that be profound, sad and discreet groundly-learned and deeply studied in physic.

COMPLETE FRACTURE OF THE FEMUR IN AN INFANT.

BY PEARCE KINTZING, M. D.,
OF BALTIMORE.

Although partial or "green stick" fractures, are of more or less frequent occurrence in children, yet, owing to the careful supervision usually accorded to the very young, as well as to the flexibility of their long bones, few cases of complete fracture come under observation. A considerable experience in hospital and dispensary practice, and some research into the literature of the subject, has failed to bring any similar cases to notice.

The following case was seen in conjunction with Dr. F. B. Gardner. A female child æt. nine months, which had been put out to board, was found to have fallen out of bed, and with a deformity so marked as to be noticed by the nurse.

An examination revealed a complete fracture of the shaft of the femur, at about the junction of the middle and upper thirds. When seen there was some swelling, but owing to the softness of the muscles of the thigh, the limb could be bent to a right angle in any direction, and both ends of the severed bone distinctly felt.

Although double talipes varus existed, the child was otherwise healthy, well nourished and without any signs of syphilis or rickets, and had not yet learned to walk.

A trough of binder's board was moulded, with the aid of hot water, and cut to extend from the rim of the pelvis to the heel, and secured as firmly as possible; but the restlessness of the child and the carelessness of the attendants allowed the infant to liberate itself very promptly from the thralldom of the splint, and at each subsequent visit during the first week, displacement was always found. At the end of that time, swelling having entirely subsided, a plaster cast was moulded, to extend from the

toes to the rim of the pelvis, and supplemented by a wide chest bandage; these being connected by a heavy strip of binder's board. This apparatus, though cumbersome, was most effectual, and displacement did not recur.

It was found necessary to retain the splint until the thirty-fifth day after the accident. Frequent examinations were made, but not until the end of that period had firm union occurred.

601 West Franklin Street.

TREATMENT OF OBSTRUCTIVE DYSMENORRHœA.*

BY THOMAS MORE MADDEN, M. D.,
F. R. C. S. ED.

Physician to the Hospital for Sick Children, Dublin;
Obstetric Physician and Gynæcologist Mater
Misericordiæ Hospital; Examiner Conjoint
Board Royal College of Surgeons and
Apothecaries' Hall, Ireland; Consultant
National Lying-In Hospital; Ex-President
Obstetric Sections of the Royal Academy
of Medicine, Ireland, and of the
British Medical Association; For-
merly Vice-President British
Gynæcological Society; M. D.
Honoris Causa Texas
Medical College, etc.

In the recognition of obstruction from cervical stenosis as the chief cause of dysmenorrhœa, will be found the key to the pathology and successful treatment of this condition in the great majority of cases. Thus in my hospital practice during the past twenty years, nearly eleven per cent. of sterility similarly caused have come under observation in a total of nine thousand gynæcological cases. Of all the ailments of female existence, few give rise to more persistent suffering, or produce more disastrous effects on the general health, and even on the cerebro-nervous system, or on the moral constitution of the patient, than does well-marked obstructive dysmenorrhœa. The latter consequence is more especially evident in many cases of alco-

holism, which in women may very frequently be dated from their first painful menstrual period, for the relief of which stimulants are too often improperly administered and repeated in increasing doses, until finally, in many cases, the victim of dysmenorrhœal alcoholism becomes a habitual, and, perhaps, an incurable drunkard.

It is not my purpose here to refer to the successive improvements which have since been effected in the methods of carrying out the gradual dilatation of the cervical canal, since the introduction into practice by Simpson and Sloan of sponge tents or laminaria bougies for this purpose. No greater improvement has occurred in our branch of surgery than the replacement of these oftentimes unsatisfactory, possibly hazardous, or even fatal, and always painful procedures by the more effective means now at our disposal for the rapid expansion of this canal. Of these, perhaps, the best known and most generally employed are either Hegar's, Duke's or Lawson Tait's dilators.

I now desire to call attention to another instrument which I have designed for the same purpose, and which, I venture to hope, may be found to supply a want still recognized by the gynæcologists —namely, that of a reliable and effective means of securing the rapid and permanent dilation of the cervical canal in the treatment of stenosis giving rise to the morbid conditions now under consideration. This instrument differs from other dilators in several respects, and, above all in one which I consider most important—viz., in producing expansion of the canal within outwards—in other words, in imitating the natural process of expansion from the uterine cavity downwards to the os uteri: whereas most other dilators, such as Hegar's, &c., act in the opposite direction. In my own hands the utility of this instrument, the expansion affected by which may be measured by the affixed index, has been fully tested in a very large number of cases of sterility and dysmenorrhœa in hospital and private practice,

*Abstract of a paper read at the International Medical Congress, Berlin, August 6th, 1890, before the Obstetric Section.

I may add that my dilator, which does not occupy more room than the ordinary sound when introduced, may also be used with advantage for the dilatation of the female urethra in many cases in which this procedure is indicated. This instrument has been carefully made in accordance with my directions by Messrs. Arnold and sons, West Smithfield, London.

Society Reports.

CLINICAL SOCIETY OF MARYLAND.

STATED MEETING HELD MAY 2ND, 1890.

The 234th meeting of the Clinical Society of Maryland was called to order by Dr. J. Edwin Michael in the chair, President and Vice-President being absent.

Dr. Howard A. Kelly read the first paper entitled

PUS IN THE PELVIS.

In the paper Dr. Kelly spoke of the importance of the subject not only to the specialist, but to the general practitioner as well, because it is not advisable for us to wait as was once the case in these conditions. He called attention to some of the points of diagnosis and advised laparotomy for the relief of the affection. He also called attention to the temperature present in this condition and showed the change that took place after operation. He spoke of what he termed a normal laparotomy chart, a composite chart taken from a number of cases he had observed. He thought that such a chart would be useful to those doing laparotomies in order to give them an idea what to expect after such an operation.

Dr. W. P. Chunn said that most of us who have seen these cases are agreed as to the best method of treatment. We

used to watch and wait, but that ought to be a thing of the past. In the last five years he has seen three such cases and they all died and the autopsy showed the cause. It is very seldom that we can find a specific cause for the trouble, but he always questions the patient thoroughly in reference to gonorrhœa.

Dr. B. B. Browne said that this is a very interesting subject. In reference to the etiology Mr. Tait says that the gonococcus is very seldom found in these cases. Gonorrhœa in the female frequently affects the os uteri as well as the vagina and gleet in the male is competent to infect for a long time after an attack of gonorrhœa.

Dr. W. E. Moseley said that he wished that Dr. Kelly had gone more fully into the diagnosis of this affection. Some cases are very easy to make, others extremely difficult. In some instances the pus is outside of the tubes. Rise of temperature does not always mean the presence of pus.

Dr. Randolph Winslow said that he has had a small experience in this line himself and the causation in his cases was either due to gonorrhœa or miscarriage. He has seen gonorrhœa of the vagina on many occasions. When the symptoms are of that character to justify an operation we can make the diagnosis later on and any fair operator, with average diagnostic acumen, can with cleanliness get good results in these cases.

Dr. Thos. Opie thought that the difficulty in these cases was that they did not seek aid in time and that if we could reach them in the earlier stages they could be treated more successfully. In reference to the treatment, that while it is advised to open a pointing abscess in the vagina when it can be done, he thinks it is better to do a laparotomy. He then related a case where he drained such an abscess and subsequently uremic convulsions came from injury done to the ureter.

Dr. George H. Rohé said that he differed from Dr. Winslow because we should always try to make a diagnosis. Dr.

Kelly's remarks in reference to the temperature are important, but he does not think that composite charts mean very much; he thinks his number of cases too small from which to draw very valuable conclusions. Some persons have much more moveable temperatures than others.

Dr. A. K. Bond said as these cases are of great interest to the general practitioner he would like to ask Dr. Kelly when the temperature was taken in his series and how he treated cases that opened into the vagina?

Dr. H. A. Kelly said the temperatures were taken at 8 A. M., and 6 P. M., daily and in the mouth when possible. As a rule he deprecates the treatment of this condition by way of the vagina. It is sometimes a most difficult procedure; we may have loculi of pus present and fail to relieve even by puncture. It was not uncommon in times gone by for many cases to get well without operation. When he finds a case about to perforate into the vagina he would puncture and tear the opening larger, then introduce his fingers and tear up the loculi. Practically he agrees with Dr. Winslow that diagnosis is of no use in these cases, but from a scientific stand point we should always endeavor to find out the nature of the trouble.

Composite charts will be good when a sufficient number of cases are collected. By tearing these abscesses we are more apt to avoid injury to the ureter. The microscope has revealed pus in the tube when none was visible to the naked eye. These pus cases are prone to run a long chronic course.

Dr. Geo. A. Fleming read a paper on

MONSTROSITIES,

and exhibited a specimen.

Dr. W. S. Gardner wanted to know if Dr. Fleming had examined the cord to see how many vessels ran through it?

Dr. G. A. Fleming said he had not, but the placenta was partially divided as if two were present though joined together.

Dr. R. M. Hall read a letter from Prof. W. H. Welch in reference to a specimen of "fibrinous cast from the uterus" he, Dr. Hall had previously reported to the society.

The microscopic diagnosis was sloughing myoma uteri.

W. J. JONES, M., D. Sec'y,
1238 Greenmount Ave.

SALVE FOR ALOPECIA.

Morwin recommends, in *L'Union Médicale* for June 28, 1890, the following salve for alopecia:

R	Gallic acid	45 grains.
	Essence of lavender	15 drops.
	Vaseline	1½ ounces.
	Castor oil	6 drachms.

This is to be well rubbed in at night over the part affected.—*Medical News*.

VIOLET MOUTH-WASH.

The following is said to be an excellent mouth-wash:

R	Tincture of benzoin	* 7 parts.
"	" rhatany	30 "
"	" myrrh	60 "
"	" orris root	500 "
	Rose water	250 "
M—	Alcohol	250 "

—*American Practitioner and News*

TREATMENT OF ANAL FISSURE.

L'Union Médicale for June 28th gives the following formula for the treatment of anal fissure:

R	Boric acid	45 grains.
	Hydrochlorate of cocaine	15 grains.
	Lanolin	1 ounce.

This is to be made into an ointment and applied to the fissure, after which the spot is to be touched with a solid stick of silver nitrate.—*Medical News*.

MARYLAND MEDICAL JOURNAL

Weekly Journal of Medicine and Surgery,

WILLIAM B. CANFIELD, A.M., M.D., Editor

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BALTIMORE, AUGUST 23, 1890.

Editorial.**COPPER COLIC.**

It is well known that the prolonged administration of copper salts in medicine produces in certain instances a form of colic, attended by certain nervous symptoms, due to systemic poisoning. These symptoms may result also from the use of acid foods which have been cooked in copper vessels. Artisans who are engaged in copper works, frequently exhibit these symptoms in very intense degree.

In the *Report of the Connecticut State Board of Health XII*, 1889, page 242, Dr. Hoyt gives a striking description of the disease as it occurs in the copper works of Bridgeport. In 1888 he was called to attend a

workman who had been occupied for three years in a department where copper is rolled while in a hot state. The temperature of the room in which he worked was very high, and the air was full of an orange-colored vapor. This was evidently a salt of copper, (the oxide?) since it was given off only when the copper was subjected, while very hot, to great pressure, at which times it was so dense that objects could be seen only at a short distance.

The patient, when first seen, was suffering from intense clonic spasms, each lasting about five minutes, the abdomen being somewhat retracted and the pain being excruciating. The paroxysms recurred about every ten minutes. The gums were purple-red, but there was no green nor blue deposit on the teeth. The hair and scalp were stained grass-green. The perspiration was free, and stained the clothing and bedding with which it came in contact, a deep green color. The pulse was somewhat rapid, full and hard. The diseases yielded after several days to morphia, iodide of potassium, and castor oil. In order to relieve the pain, sufficient morphia was given to produce marked slowing of the respiration and extreme smallness of pupils. Unconsciousness was not produced, and sharp pressure over the chest muscles would excite inspiration, any disturbance of the patient bringing on the pains again. The permanent relief and the beginning of convalescence appears to date from the time when free action of the bowels was procured by the castor oil. The return of health was rapid.

Two other cases pursued similar courses, and were treated in the same way by Dr. Hoyt. These patients returned to work in two or three days.

Since, in the cases first mentioned, there is no record of any irritation of the respiratory passages, which might be expected if the copper was absorbed through these parts, and since the patient had been working in the same department for three years, it is natural to suppose that his system had become somewhat used to the absorbed poison and that the sudden appearance of toxic symptoms was due to some unwonted condition of the patient at the time of the attack.

The green stain produced by the sweat would be more readily explained by supposing that the sweat took up copper salts which had been deposited on the skin, than by supposing that the sweat itself contained the salt when secreted. This green color in the stools and other discharges is the main symptom by which copper poisoning may be distinguished from intoxication by lead and other metals. The diagnosis is generally made from the history of the case.

THE TREATMENT OF SOFT CHANCRES BY CREOLIN.

The new antiseptic creolin, which has been so extensively adopted in obstetrical practice, has been used with great success by Dr. José Busque of Brazil, in the treatment of soft chancres (*Bulletin Général de Thérapeutique*, July 15, 1890.)

In using it at his clinic in the solution or emulsion of 12 to 20 per thousand, he noticed that the ulcerations rapidly healed, even in cases where corrosive sublimate and iodoform had done no good. When the applications are to be made frequently, he used compresses of iodoform gauze over the creolin with advantage. That this good effect was

not due to the iodoform was shown by the successful use of creolin in cases where iodoform had not healed. He advises the use of both together.

Correspondence.

TOMATO SORE MOUTH AND THROAT.

BALTIMORE, AUGUST 5TH, 1890.

Editor Maryland Medical Journal:

DEAR SIR:—On July 7th, a stout healthy man consulted me with what he termed "The Summer Sore Throat," which had afflicted him every summer and autumn for several years.

Examination revealed an almost complete loss of the epithelial covering of the pharynx and epiglottis, with the vocal cords and lining of larynx very red and irritable. Deglutition was difficult and painful, with occasional alarming spasm of glottis.

I at once began the treatment usually pursued by specialists in such cases, but failed to benefit for ten days, at the end of which time I incidentally learned that he was in the habit of daily eating from three to ten fresh, raw tomatoes freely sprinkled with salt. Believing that his affection might be due to the combination of the sharp tomato acid with the table salt, they were interdicted, and the treatment which had previously failed began at once to be successful.

Curiously enough July 27th, I met with another case almost identical in history, in which the salted tomatoes were also stopped, and it likewise yielded promptly to treatment. This case (gentleman age 41) was accompanied with annoying conjunctivitis, sneezing and a stuffy feeling in the naso-pharynx, somewhat similar to that observed in hay-asthma.

If anyone has encountered cases similar to these, and found them due to the same cause, I would deem it a favor if they report them, as I have been unable to find any mention of it in our literature.

Wm. T. CATHELL, M. D.

Reviews, Books and Pamphlets.

A Treatise on Orthopædic Surgery. By EDWARD H. BRADFORD, M. D., and ROBERT W. LOVETT, M. D. New York: William Wood & Co., 1890. Pp; 783, price \$6.00.

These authors consider that the term "orthopædic surgery," if properly defined, should include the prevention as well as the cure of deformity. Inasmuch as diseases of the joints are among the most common sources of deformity and disability, this class of troubles has been studied at considerable length. Endeavor has likewise been made to treat of such subjects as are likely to come to the attention of those who interest themselves in this general branch of surgery. Thus in addition to a consideration of joint disease and Pott's disease, there has been added a brief description of some disabling and deforming nervous affections, which are discussed in their practical surgical aspect.

The chapter devoted to etiology, course, and termination of chronic joint disease is an important one. The following constitutional pathological conditions are considered to have a most important part in causation:—tuberculosis, syphilis, rheumatism, arthritis deformans, gout, acute infectious diseases and miscellaneous conditions. References and quotations are made from many medical journals and authors, including Müller, König, Gibney, Croft, Shaffer, Sonnenberg, Lannelongue and Sayre. Statistics and quotations from numerous diverse sources are apt to become confus-

ing, and we think our authors would have done better to have condensed this portion of the work more, simply giving conclusions in brief form. Under the miscellaneous conditions of joint disease, the so-called growing pains are considered. These slight pains are defined to be chiefly in the juxta-epiphyseal region, most commonly near the lower epiphysis of the femur. The pain, which is brought on by fatigue, strains or exposure, may last for several days and be accompanied by slight fever. In the severest form the affection may continue for months. It may occur during the ages between five and twenty-one. The authors consider that growing pains proper are neither severe nor permanent, and that a great amount of harm is done in referring to this class, the pains of beginning chronic joint disease. Writers on pediatrics are in no danger of falling into such an error, as we are under the impression that growing pains are considered to be mild manifestations of rheumatism in early life, and we are surprised that no mention is here made of this conception of these pains.

A very thorough account of infantile spinal paralysis is given, including etiology, pathology, symptoms, differential diagnosis, prognosis and treatment. During the stage of paralysis, the object of treatment should be first to support the affected limb in a normal position, and most carefully guard against the stretching of joints, ligaments and muscles; and, secondly, by the use of electricity, massage and systematic exercise to keep the nutrition of the affected muscles in the best possible condition. The authors insist that muscles do not contract, and deformities do not come on in properly supported limbs. The mechanical treatment of this disease often presents a most difficult problem, and is here thoroughly discussed and illustrated by many wood-cuts.

The volume closes with a brief consideration of the functional affections of the spine and limbs. It may not be invidious to state that we wish some of the

other articles in this work had more of the element of brevity. Most of the subjects are here exhaustively treated, but we think much needless matter has been included. The need of the profession is for writers on special subjects who can be at the same time fairly exhaustive and tolerably brief.

The New Treatment of Peritonitis. By EMORY LANPHEAR, M. D., Kansas City, Mo. Reprinted from the *Kansas City Medical Index*, July 1890.

The Responsibility of Dipsomaniacs. By THOMAS B. EVANS, M. D., of Baltimore. Reprinted from the *Journal of the American Medical Association*. June 7th, 1890.

Miscellany.

INTESTINAL ANTISEPSIS.

At the recent meeting of the Ninth Medical Congress in Vienna, Professor Cantani read a paper on the subject (*La Médecine Moderne*, May 1, 1890,) in which the credit for having first attempted intestinal antisepsis was given to Boucharde, who treated his typhoid fever patients with a mixture of charcoal and iodoform, naphthol in large doses, or even salicylate of sodium. The efficacy of this treatment is, however, still doubtful, and substances administered in the form of a solid, can only with difficulty penetrate the intestinal mucous membrane, which is the seat of the pathogenic microbes. Cantani, therefore, suggests washing out the intestine by means of enemata, so as to act directly on the intestinal membrane, and so accomplish intestinal antisepsis much more reliably than by the administration of remedies by the mouth.

The great difficulty, however, is to pass the ileo-cæcal valve, but this is, however, by no means entirely impossible,

since he injected into the rectum of a patient a large quantity of olive oil, and found one hour afterwards the patient had vomited the oil. The oil had, therefore, passed the ileo-cæcal valve and also the pyloric sphincter. It therefore becomes possible to wash out the small intestine by the injection of enemata made antiseptic by the addition of carbolic acid, tannic acid, or sublimate. The two former are the more reliable, since the sublimate tends to combine with the albuminous substances found in the intestine, and thus form an absolutely insoluble precipitate of albuminate of mercury. Pure oil itself is an excellent antiseptic. Tannic acid is the best. It may be administered in very large doses, and is endowed with considerable power as a microcide. In one per cent. solution tannin kills the microbe of cholera in pure cultures. The author does not claim that these enemata kill all microbes, but they suffice to largely prevent the growth of the microbes and make the intestinal medium unfavorable to their development.

Thus, in the commencement of typhoid fever, if the bacilli are still on the surface of the mucous membrane, this use of the antiseptic injection appears of undeniable value, but later, when the bacilli have penetrated Peyer's patches, this action is no longer possible, but even then the injections diminish or neutralize the virulence of the ptomaines formed in the intestine.—*Therapeutic Gazette*.

TREATMENT OF BRIGHT'S DISEASE.

Senator advises the patient to live in a dry and equable climate, and almost exclusively upon milk as a diet. No red meats are allowed, and white ones only in strict moderation. Fruits, herbs and cereals may be taken, but spices are interdicted. Dilute wines are allowed in small quantities.

Bamberger's treatment is an exclusive milk diet, with the following iron pills (*L'Abeille Méd.—Med. News*):

R Chloride of iron, gr. iiij.
Ext. taraxacum, q. s.—M.

Sig.—One pill three times a day.

Or,

R Sulphate of iron, }
Bicarb. sodium, } of each 75 grains.
Ext. taraxacum,

—M.—Make into sixty pills, of which three should be taken in the morning and three at night.

Semmola also insists on a diet of milk, and gives the following mixture:

R Iodide of potassium, gr. xv.
Phosphate of sodium, gr. xxx.
Chloride of sodium, ʒ j
Aqua, ʒ iiij—M.

Sig.—To be taken in twenty-four hours.—*Canada Larvæt.*

THE DANGERS OF CONSTIPATION IN CHILDREN.

In a lecture recently delivered before the Paris Hospital for Sick Children, Dr. Jules Simon (*Journal de Médecine et de Chirurgie*, May, 1890) called attention to the fact that while diarrhoea occurring in children was the object of the most extreme solicitude both on the part of parents and physicians, constipation, which possesses almost as great danger, was almost entirely neglected. He called attention to the case of a girl, 15 years of age, who was brought into the hospital suffering from extreme abdominal pain, following a fall upon the abdomen, which was, as is often the case, followed by an abscess in the abdominal walls. The symptoms, however, rapidly increased in intensity, and were followed by vomiting and diarrhoea, and the patient died at the end of a few days. At the autopsy there was noted general peritonitis, with perforation of the cæcum, surrounded by an old purulent deposit in this region. There was thus typhlitis, followed by perforation, which led to the formation of an encysted abscess in the

pelvis, and only as the result of injury was general peritonitis produced. Dr. Simon believes, from the nature of the lesion observed, that the inflammation and the perforation were the consequences of marked constipation, leading to a rapidly fatal termination by traumatism. He believes that cases similar to the one reported are much more common than is ordinarily supposed, and he thinks that in many cases faulty development and numerous digestive disturbances are attributable to more or less obstinate constipation. Indeed, even in some cases death itself may follow either through the production of typhlitis and the perforation of the cæcum, as in the present case, or from intestinal obstruction. In another case Dr. Simon stated that he had seen death produced by a stercoraceous tumor the size of a child's head. In such cases the author states that he has frequently obtained satisfactory results through the employment of electricity, but then, when the obstruction has been overcome by this means, it must be recognized that the patients are constantly exposed to a return of a similar state of affairs; for the intestinal tube, after such great distention, becomes the seat of structural modifications, so that it becomes almost incapable of resuming its normal condition. There is thus a practical point to be observed, whose neglect may be followed by the most serious complications, and in examination for the cause of obscure infantile troubles the occurrence of constipation as a possible factor should never be overlooked, especially as constipation may be actually obscured by an apparent diarrhoea.

—*Therapeutic Gazette.*

SOME SOURCES OF ERROR IN SOUNDING FOR STONE.

Mr. Buckstone Browne (*Harveian Society of London*) said his first proposition was, that in cases where the prostate was enlarged, stones are often missed when the bladder is examined, because the sound has not reached the bladder, but is arrested in the prostatic urethra. He

illustrated this by several examples, and expressed an opinion that in many cases where the bladder was found contracted and the sound could not be turned, the real truth was that the sound had never entered the bladder. Next he proved that many stones were missed because the post-prostatic pouch is not explored, or not fully explored. It was shown that in certain cases it was very difficult to explore this pouch by means of instruments passed in by the urethra, and that in certain other cases it was impossible to do so, and that in these rare cases, the only way to thoroughly search was by means of supra-pubic incision into the bladder. Several interesting and important cases from the author's personal experience were cited in illustration. The sound described was of solid burnished steel, with a round smooth handle, a shaft ten inches long and equal to No. 7 of the English scale, ending in a smooth broad flat beak, exactly like the end of a broad flat-bladed lithotrite. The author asserted that the beak of this instrument allowed it to ride easily over the bar at the neck of the bladder, and that it was not caught in one or other prostatic sinus as the end of the ordinary sound was so prone to be, and that when in the bladder it slipped more easily than an ordinary sound under a projecting prostatic middle lobe, and so enabled the surgeon to thoroughly search that favorite habitat of stone—the post-prostatic pouch.—*Med. Press and Circular.—Canada Medical Record.*

THE TUBES AND OVARIES IN PREGNANCY.

Dr. H. Thomson, of Dorpat, has published some observations on this subject in the *Zeitschrift für Geburtschilfe*. He found that in pregnancy and the puerperium; the tubes underwent noteworthy histological changes. The connective tissue became more vascular and succulent and appeared also actually to increase in amount during pregnancy. The muscular coat hypotrophied as in the uterus although to a less marked degree. These

conditions underwent retrogressive changes in the puerperium, as was distinctly observed by Dr. Thomson in the muscle cells. No palpable change was detected in the ovaries either during or after pregnancy. The fact must not be omitted that there researches were made on the tubes and ovaries of rabbits. The cornua of the uterus in rodents are homologous to a large segment of the tube in woman. The ovaries in rabbits are not subject to precisely the same physiological changes during adult life as in woman.—*British Medical Journal.*

PÄEDIATRIC THERAPEUTICS.

ECZEMA IN CHILDREN.

Delapert recommends the following formula:

R	Acid. boric.,	gr. lxxx.
	Balsam. Peruvian.,	gr. viii.
	Vaseline,	$\frac{3}{2}$ i.—M.

Ft. unguent.

S. Apply.

DIARRHœA IN CHILDREN.

Braithwaite relies upon the following mixture:

R	Ferri sulphat.,	
	Sodii salicylat.,	āā gr. xii.
	Glycerin.,	f $\frac{3}{2}$ ss.
	Aq. destillat.,	f $\frac{3}{2}$ iiiss. M

S. Teaspoonful every one, two or three hours.

TREATMENT OF THE SURFACE OF THE BODY DURING THE DESQUAMATION OF SCARLATINA.

Dr. Louis Starr in a recent clinical lecture, strongly advocates the antiseptic treatment of the desquamating cuticle in scarlet fever, both as a means of disinfecting and preventing dispersion of the scales, and also as hastening the process of desquamation. He commends the use of thymol:

R	Acid. carbolic.,	gr. xx.
	Thymol,	gr. x
	Vaseline vel unguent simp.,	ʒ i. M.

LOCAL TREATMENT OF PHARYNGEAL
DIPHTHERIA.

Every hour the affected surface should be well swabbed with the following mixture:

R	Acid. salicylic.,	gr. iiij.
	Alcohol.,	q. s.
	Glycerin.,	f ʒ iiiss.
	Infus. eucalypti.,	f ʒ iiiss.

M.

If the false membrane resist this, recourse should be had to

R	Ferri chlorid.,	
	Glycerin, ॥ ॥	f ʒ ss. M.

After the use of this application a gargle or atomization of a solution of boracic acid, two per cent., or of lime water is to be used.

FOR ADENITIS.

R	Extract. belladonnæ,	gr. xxxvi.
	Potass. iodid.,	gr. xxiv
	Vaseline,	ʒ viii.

Ft. unguentum.

S. Apply.—*Annals of Gynaecology and Paediatrics.*

WHAT AMMONIA CAN DO.

A little ammonia in tepid water will soften and cleanse the skin.

Spirits of ammonia will often relieve a severe headache.

Door plates should be cleaned by rubbing with a cloth wet in ammonia and water.

If the color has been taken out of silks by fruit stains, ammonia will usually restore the color.

To brighten carpets, wipe them with warm water in which has been poured a few drops of ammonia.

One or two tablespoonsful of ammonia added to a pail of water will clean windows better than soap.

A few drops in a cupful of water, applied carefully, will remove spots from painting and chromos.

Grease spots may be taken out with weak ammonia in water; lay soft white paper over and iron with a hot iron.

Keep nickel, silver ornaments, and mounts bright by rubbing with woolen cloth saturated with spirits of ammonia.

When acid of any kind gets on clothing, spirits of ammonia will kill it. Apply chloroform to restore the color.

Ammonia applied two or three times on a fresh cold sore will kill it. It will drive it away if used when the cold sore is first felt.—*Sanitarian.*

RETENTION OF THE MEMBRANES
AFTER DELIVERY.

Many of the simplest questions relating to obstetrics are still under dispute. Amongst these is the management of the placenta and membranes. Some authorities advocate an expectant system, leaving the placenta to be delivered by aid of the uterine contractions alone, unless those contractions prove insufficient. Others, after Credé, believe that a routine practice of expression is in accordance with sound obstetric principles. Dr. Eberhardt has made observations in order to ascertain why the retention of membranes sometimes produces no bad effects, and in others causes grave, if not fatal, complications. Kaltenbach has shown that the danger of retention of membranes does not arise so much from the pieces of placenta or clots which are left behind in the uterus, but rather from the admixture of bacteria with these elements. Clinical research has proved that bacteria do not exist in the uterine cavity. Döderlein and Winter have shown that bacteria are not found in the uterus and tubes of healthy women, but naturally exist in the vagina and in the canal of the cervix—the latter being now universally reckoned as a distinct organ from the rest of the uterus. The internal os appears to be

the line of demarcation between the segments of the general canal which normally contain, and those which naturally do not contain, bacteria. On this theory, Eberhardt bases a line of practice. Access of germs to portions of membranes in the uterine cavity must be prevented; all such portions engaged in the cervix and vagina must be carefully removed, whilst ergot should be given to expel them. Manual expression seems contra-indicated. The vagina must be freed from germs by antiseptic injections.—*British Medical Journal*.

PARTIAL RESECTION OF THE DISEASED OVARY AND TUBE.

Dr. Martin, of Berlin, has systematically practised the partial removal of ovaries not entirely diseased. In some cases he has also resected part of the tube, and made, by suture of the mucosa to the serous coat, a new ostium. This proceeding has been termed "salpingostomy" by Dr. Skutsch, of Jena, and has also been advocated by Wallace and Schröder. Dr. Martin, as the result of his experience, published in Volkmann's *Klinische Vorträge*, came to the following conclusions: Patients recover perfectly after partial removal of ovaries for localised chronic inflammatory changes, hydrops folliculi and oophoritis. Recovery is also complete, in most cases, after the resection of obstructed and otherwise diseased tubes. The after-histories of seventeen patients operated upon by Dr. Martin prove that women with resected ovaries and tubes are not more exposed than other women to further disease of the parts left behind. Menstruation continued in all the cases, and some conceived. Dr. Martin notes that in 1864, Sir Spencer Wells emptied some drop-sical follicles in one ovary of a young girl, having just removed its fellow. The girl afterwards married, and had children. The first resection of the ovary, performed intentionally, was undertaken by Schröder in 1884. A dermoid cyst occupied part of an ovary (the fellow in this case also formed a tumour and was

removed), it was cut out, and the wound in the ovary was sewn up. The patient appears, according to a note in Hofmeier's *Grundriss der gynäkologisch. Operat.*, to have conceived after the publication of Schröder's own report of her case.—*British Medical Journal*.

CRANIECTOMY FOR MICROCEPHALUS.

At a recent meeting of the Académie des Sciences, M. Lannelongue reported a case of craniectomy in a microcephalic idiot, which was attended with results so striking that the case is well worthy of careful study. M. Lannelongue's communication, the gist of which was given by our Paris correspondent in *THE LAN-*
CET of July 19th, p. 152, is printed in full in a recent number of *L'Union Médicale*. The most salient features of the case are as follows: The patient was a female child four years old, but looked two years younger. The head was very small, narrow from side to side, and projecting at the vertex; the only diameter which approached the normal was the antero-posterior, all the others were much below the average. The child was puny, seemed to take no notice of her surroundings, and lay in bed restless, stammering out monosyllables or inarticulate cries. She was unable to stand, and if supported made no effort to walk, but stamped her feet with rapidity. The child was a well-marked example of a microcephalic idiot. M. Lannelongue operated upon her in the following manner. Having made an incision through the scalp and pericranium, just to the left of the sagittal suture, a small circle of bone was removed with a trephine at a point a finger's breadth from the suture; from this as a starting point a narrow strip of bone, nine centimetres long and six millimetres broad, was cut away, parallel with, and to the left of, the sagittal suture, the aperture in the skull extending from the coronal to the lambdoidal suture. The dura mater was left intact; the scalp wound was carefully closed by sutures, without a drain, the periosteum not being replaced across the bony defect.

This operation was performed on May 9th, and the child made an excellent and uninterrupted recovery. On June 15th, it was reported that the child's condition had undergone a notable change for the better since the operation. She was quieter; the inarticulate cries had ceased, she took an interest in surrounding objects, understood when spoken to, and even tried to talk. She could stand alone and even walk a little. As M. Lannelongue remarks, some of this improvement must be put down to the effect of the careful training of the child while in the hospital, but such a rapid and striking change can hardly be wholly so explained. The case is certainly a most interesting one, and further reports of it, and of a second similar case in which M. Lannelongue operated on June 20th, will be anxiously awaited. If the premature synostosis of microcephalus is the primary condition, the operation seems to rest upon a sure pathological basis. If, however, the synostosis is only secondary to defective development of the brain, still the operation, as a means of influencing the nutrition of the brain, may be amply justified.—*Lancet.*

SPIROMETRY.

M. Joal of Mount Doré has made a number of observations in spirometry that lead him to the conclusion that many nasal and pharyngeal affections produce a distinct diminution in the capacity of the lungs. Thus in cases where hypertrophic rhinitis, adenoid tumours of the naso-pharynx, chronic coryza, &c., have been cured, the capacity of the lungs, as measured by the spirometer, is frequently increased by a quarter, and occasionally even doubled. M. Joal has frequently found that public singers, when they complained of fatigue of the voice or of diminution in its power or range, are suffering from some, perhaps quite unsuspected, trouble in the nose or pharynx, and that if this is cured the voice recovers itself completely. He

suggests that professional singers should know their own respiratory capacity, and that this should be occasionally tested, so that any diminution may serve to give a warning of possible mischief in the nose or pharynx, which if attended to in time may be met by appropriate treatment.—*Lancet.*

Medical Items.

Dr. James Bordley has returned from Europe.

Dr. John Whitridge Williams has returned from Europe.

Dr. J. J. Chisolm read a paper on "Cataract" at the International Medical Congress.

Dr. H. P. C. Wilson has returned from Europe and has gone to Chicago on professional business.

The Mesopotamian epidemic of cholera has commenced to spread northwards towards the Black Sea.

The Medical Examining Board of Virginia will meet at Rockbridge Alum Springs, September 2, at 8 P. M.

The President has appointed Dr. J. H. Baxter Surgeon-General of the Army, in the place of Surgeon-General Moore, who has reached the age limit.

The Medical Society of Washington County, Maryland, held its regular meeting at Hagerstown, last Wednesday. Fuller particulars will be published next week.

The Cecil County Medical Society will hold its next meeting at Port Deposit, on August 29th. Dr. John Morris, of Baltimore, will read a paper on "Puerperal Insanity."

Dr. J. B. McKee, a well known and highly esteemed physician of Hagerstown, died a few days ago at an advanced age. He was a graduate at the University of Maryland in 1832.

Dr. W. F. Westmoreland has been elected to the Chair of Surgery in the Atlanta Medical College, left vacant by the death of his father.

A Paris correspondent states that the Montpelier municipality has resigned on account of the Government having half promised a medical faculty to Marseilles. The result is that marriages are at a standstill, there being no mayor to officiate.

The *Chicago Tribune* tells of a Missourian who died from having gorged himself with veal and hard cider. He was a member of several societies, all of which passed resolutions imputing his removal to Divine Providence.

There appears to be a dearth of water in Southern Italy just now. It has not rained for a month, and it is feared that very shortly the water-supply of the houses will be exhausted. Naples and other large towns, however, are well provided.

The three most successful physicians in this country are Dr. J. H. Parker of the Park National Bank, New York; Dr. Jesse Seligman, of Seligman Brothers, bankers; and Dr. Norvin Green, President of the Western Union Telegraph Company. None of these practise medicine, however.

The Thirteenth Annual Reunion of the Pennsylvania and Maryland Union Medical Association will be held this year at York Pa., on Thursday, August 28th. Dr. I. C. Gable of York will deliver the address of welcome, and the annual address will be given by the President, Dr. J. M. Deaver of Lancaster county. Ex-

cursion rates are given upon orders, obtainable from Dr. Alex. Craig, of Columbia.

In the University of Rome there has just been opened a Laboratorio di Psichologia Sperimentale, in connection with the Anthropological Institute. Its superintendent is Professor Sergi, whose work in medico-psychology is well known in Italy and on the Continent.

The German Government have added considerably to the annual subvention by which they keep up the Station of Marine Zoology at Naples, so as to make it more than ever the resort of students in natural history from all parts of the world.

Dr. Flint is quoted as saying: "I have never known a dyspeptic to recover vigorous health who undertook to live after a strictly regulated diet, and I had never known an instance of a healthy person living according to a strictly dietetic system who did not become a dyspeptic."

Dr. R. C. Word, a prominent physician of Georgia, died July 20. He occupied the position of Professor of Physiology in the Medical and Dental Departments of the Southern Medical College in Atlanta, and was for many years associate editor of the *Southern Medical Record*. He was graduated at the University of the City of New York in 1846.

The Russian Government has ordered that all medical and pharmaceutical students shall be henceforth accustomed to the decimal system of weights and measures, with the view of making this system the only legal one for prescriptions to be written in after the lapse of five years, as it is intended to abolish altogether the use of the so-called Nürnberg weights, which are still in very general use in prescribing and dispensing.

MARYLAND MEDICAL JOURNAL.

VOL. XXIII. No. 18. BALTIMORE, AUGUST 30, 1890.

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Original Articles.

IS SMOKING IN MODERATION DELETERIOUS TO HEALTH?*

BY THOMAS M. NORTON M. D.,
WASHINGTON, D. C.

The subject of my remarks—Is smoking in moderation deleterious to health, was suggested to me in a somewhat peculiar as well as amusing manner. On the afternoon of the 20th of January, 1889, having spent the morning in wading around through the snow and slush, which, as some of you may remember, was imposed upon us on that date, and having completed my work for the day, I had exchanged my coat and shoes for dressing gown and slippers, and seated in a comfortable rocking chair before a blazing fire, with a lighted cigar between

my teeth, I was congratulating myself upon being indoors on such a day and lazily scanning the daily papers, when my eye was caught by the following "heading" which stood out in bold relief—"Puffed himself into his grave."

The accompanying article gave a most graphic and thrilling description of how a foolish youth had prematurely ended his life wholly and solely by the use of tobacco, and concluded with an exhaustive tirade against this dangerous and disgusting vice. Asserting very positively that every cigar, pipe, or cigarette indulged in is an irretrievable step the unfortunate victim is taking towards his grave.

As I finished reading the article, a cloud of smoke passing before my eyes, attracted my attention to the cigar I was smoking, and the startling question flashed through my mind as to whether at that very moment I was engaged in the alarming occupation of shortening my life.

*Read before the Clinico-Pathological Society of Washington, D. C.

That tobacco, excessively indulged in, was a harmless luxury I had never for a moment conceived, and I was well aware too that its abuse gave birth to many dangerous affections and greatly assisted in the development of others. Yet up to that moment I had believed smoking in moderation to be productive of no evils in a healthy human being, and tobacco to be conducive of harm only when its use had overstepped the bounds of moderation and become its abuse. Consequently upon the spur of the moment I determined to give the subject a more careful consideration than I had heretofore done, and subsequently I decided to present it before this Society for discussion, prompted more by the desire of hearing the views of others, than with the idea of airing any newly invented theories of my own.

To obtain a clear and correct solution of the question, it would be first necessary to inquire into the composition of tobacco smoke, then to ascertain what is formed and left in a man's throat and lungs during the process of smoking, to study the effects produced upon his system by these newly formed substances, and finally to consider the diseases to which these effects give rise. On examining into the subject I have found this a difficulty and in fact an impossible problem to solve. Up to the present time I have been able to discover no definite and correct analysis of tobacco smoke, nor has it been at all clearly established as to what is formed and deposited in a man's system by its inhalation, nor is this point likely to be soon settled, since it is impossible to procure a man's throat and lungs just after he has finished smoking. Therefore investigators have resorted to artificial processes for the attainment of this end, and from the results thus derived have drawn their conclusions and deductions.

A crude analysis of tobacco smoke by Dr. Richardson of England, showed its constituents to be these, which I give in his words.

"Water in the state of vapour, free

carbon diffused in very minute particles or soot, some ammonias existing in a state of vapour, and giving to the smoke an alkaloidal reaction, carbonic acid, and carbonic oxide, each in a state of gas, and a product coming over, also in vapour, but easily condensable into an oily-like substance, crude nicotine. This nicotine was in turn found to be complex. It yielded a fluid alkaloidal body, nicotine proper, a volatile empyreumatic substance containing an ammonia, and a dark resinous bitter extract."

Other examiners have by means of complicated chemical experiments split these results into more definite and distinct subdivisions; separating out carbonic, acetic, formic, butyric, valeric, and prussic acids, creosote, some hydrocarbons, and many other substances. The poisonous character of these would render them extremely dangerous if introduced into the system even in minute quantities; but fortunately for the smoker, his throat and lungs are not so well equipped in the chemicals necessary for these experiments, nor do they furnish so suitable a place for the performance of these experiments as does a well furnished laboratory; lacking both the complex apparatus and the power of altering the temperature, which are required for such performances; nor on the other hand is Nature so expert and successful in separating out and producing these substances in a purified and concentrated form as are our practical chemists, hence it is a rather dubious question as to whether many of them are formed in the ordinary process of smoking, else the evils of tobacco would be far more numerous and much severer than they now are.

Nevertheless, it is an undisputable fact that some injurious and poisonous matters are introduced into the system by the use of tobacco, and if permitted to remain and to accumulate unmolested they would soon augment into quantities sufficiently great to break down the constitution and destroy life.

Such, though, is not the cause; for just as Nature has furnished us the

means of freeing our bodies from the deleterious substances which are necessarily absorbed with the air that enters our lungs and the food that enters our stomachs, and just as she has provided for the removal of the waste substances thrown off during the performance of the different physiological functions of the body, so too does she here come to the rescue, and supplies the means of relieving our bodies from the harmful products of smoking. The lungs, skin, and kidneys, the three great eliminatories, here come into service and carry off these noxious matters.

Now, if these structures are materially injured in the performance of this work, there can be no question as to the harmfulness of tobacco; so to this point I wish to call the attention of the Society.

When tobacco is used for the first time, its effects are truly distressing, the salivary glands are stimulated to an excessive degree, heart palpitation is caused, vertigo and dizziness come on, nausea and vomiting are present, and a partial paralysis is produced.

From this it would appear than tobacco, even in the most moderate amount, was our enemy; and if such symptoms continued for any great length of time we could but conclude it to be deleterious; but we know from experience that in a short time all of these symptoms disappear, and the different organs are left just as they were before, and no change either pathological or histological can be found in their structure, nor are they debarred in any way from performing their normal physiological functions. Consequently, from this we perceive that these derangements are purely functional and that no organic lesions are produced; therefore the eliminatories are not materially affected. Yet if such functional derangements were present every time we smoked, tobacco would still pose as our enemy; but we know full well that the second time tobacco is used these derangements are much less severe than formerly, and in a short while they become inappreciable even to the smoker himself.

When this result is attained, a man is said to have established a "tolerance" for tobacco and here the subject is usually allowed to rest. But let us advance a step further and inquire into the meaning of this term.

When we smoke for the first time and introduce its products into the system; we call upon the eliminatories for a new work, and require them to take up and carry off a new load and one to which they are unaccustomed, and they naturally rebel at first and demand time to learn this new duty that has been imposed upon them. This is soon accomplished, and they perform it easily and naturally without injury to themselves, and leaving nothing behind that can impair the health of the smoker. And this adaptation of the eliminatories to their new function is what is meant by the establishment of a "tolerance" for tobacco.

Some people are so constituted that they never acquire a tolerance for smoking, and suffer violent functional derangements every time tobacco is used, and this has been advanced as an argument in favor of its harmfulness; but I think it hardly just to use the idiosyncrasy of a limited few as an argument against the use of tobacco, any more than it would be fair to urge as an argument against a glass of wine with one's dinner; the fact that some people are so constructed that even a teaspoonful of wine will flush their faces, stimulate their hearts, and excite their brains.

Here it will not be amiss to expound my definition of moderate smoking, for what is moderate for one may be excessive for another. Hence,

As long as a man is only loading his body with the products of tobacco smoke in quantities sufficiently small for the eliminatories to conveniently and easily carry them off, and allows these organs abundance of time to return to their normal condition, then he is keeping within bounds; but if he so crowds his system with these substances that the eliminatories are overtaxed and strained in elim-

inating them, or have not sufficient time to regain their normal structure, and thus keeps up a continuous functional derangement, then he is smoking in excess. A man's personal feeling must be his guide as to how much he can safely smoke.

Tobacco in moderation is a stimulant, while in excess it is a narcotic, and he should never permit its narcotic effects to be present even in the slightest degree.

From the preceding remarks, we perceive that smoking is accompanied by functional derangements which are at first severe, then less and less distressing until finally they become almost imperceptible, but that slight functional derangements are produced every time a man smokes, although a tolerance for tobacco has been established. Therefore we have now to consider whether or not mild functional derangements are deleterious to health.

If functional derangements were exceptional occurrences in our bodies, or were our bodies lacking in the means of successfully combating such derangements when excited, we could but admit them to be deleterious; but we know full well that such derangements are being constantly produced. They are not of yearly or monthly, but of daily, hourly, and even minutely occurrence, and nature has been most lavish in her supply of organs for counteracting such derangements, and in furnishing means for restoring the deranged organs to their normal state.

It would be a difficult task to definitely designate what constitutes the normal or natural condition of the body. Its theoretical normal condition would be where each and every portion is performing daily just so much work and resting just so much time, never varying year in and year out.

To keep the body in such a state we should have to regulate the quantity and quality of food taken in, and the time administered, exercise both physical and mental, also the waking and sleeping hours would have to be changed and reg-

ulated to suit this condition; then, too, we should have to regulate the quantity and quality of air breathed and make allowances for the changes of temperature. To obtain such a condition is an impossibility, and were such a condition attainable and could it be maintained, it would prove deleterious rather than beneficial to the victim.

Hence the natural condition of the body, or more correctly speaking, the usual condition of the body, is one in which functional derangements are being constantly produced, and they are not injurious unless extremely severe or unduly prolonged, neither of which circumstances accompanies moderate smoking.

DISEASES PRODUCED BY SMOKING.

Derangements of digestion, derangements of the throat and lungs, hypertrophy of the heart, deterioration of the blood, congestion of the brain, loss of memory, apoplexy, paralysis, derangements of the vision, loss of virility, cancer, and many other dangerous and distressing affections are laid at tobacco's door by writers on these subjects. The majority of these diseases, however, are attributed to the excessive use of tobacco, hence are not embraced in the title of my paper. But derangements of digestion and of the throat and lungs are ascribed by many authors to the use of tobacco in any quantity, and to these I shall devote a few minutes.

It is claimed by the antagonists of smoking that tobacco and dyspepsia go hand in hand. They maintain that smoking has a two-fold injurious effect upon digestion,—first, it paralyzes the muscular coats of the stomach, thus causing a stasis in its peristaltic action,—and secondly, it inflames the mucous coat of the stomach, thus decreasing the amount of gastric juice and adulterating its quality. While the advocates of tobacco claim that smoking in moderation aids digestion,

1.—By acting on the sympathetic ner-

vous ganglia and exciting an increase of digestive juices.

2.—By acting on the medulla oblongata and strengthening the circulation, and

3.—By acting on the interstitial nerve fibres and aiding in the assimilation of prepared material.

Now, although I am far from prepared to blindly accept these extreme views of the advocates of tobacco, still I think we are able to successfully repudiate the exaggerated opinions of tobacco's antagonists.

Theoretically their ideas may be correct, but a practical consideration of the subject fails to substantiate them.

If smoking had such deteriorating results upon the digestive organs, we would of course find dyspepsia much more prevalent among men than among women. Clinical experience and standard statistics demonstrate the exact reverse. In fact, I am rather inclined to agree with the advocates of tobacco, that smoking in moderation aids digestion and is of benefit in some forms of dyspepsia.

It has been conclusively demonstrated that a substance which excites the salivary glands, also acts as a stimulus to the other digestive organs, and we know that smoking stimulates the salivary glands.

Moreover, among smokers there is a more exaggerated craving for a smoke directly after eating than at any other time; and after a man has eaten a larger dinner than he can conveniently accommodate, there is no remedy more efficacious in dispelling the inconveniences which arise, than a good cigar, and this would hardly be the case if it paralyzed and inflamed his stomach, and adulterated and diminished his gastric juice.

RELATION OF TOBACCO IN MODERATION TO THE THROAT AND LUNGS.

There has been many a warm debate as to the effects of tobacco on the throat and lungs, and the question is still far from being definitely decided.

The smoker's sore throat, the exist-

ence of which is freely admitted by all, has been and is still cited as one of the evils of tobacco, but this affection is only found in excessive smokers, so is no argument against smoking in moderation, any more than is the preacher's sore throat an argument against talking.

Chronic bronchitis and consumption are the only diseases that can be correctly considered under this head, and in connection with these two diseases I will quote an extract from Dr. Richardson's essay on tobacco:

"That considerable injury to the lungs may follow from smoking during peculiar conditions of the system which have been brought on by other and more determinate causes, is certain, but, after a rigid analysis of all the facts in my possession, I doubt whether smoking can be adduced as a prime cause of diseases of the chest. I have been fortunate in having at command unusual facilities for conducting an inquiry into the precise relationships that exist between the practice of smoking and the presence of disease in the lungs.

The position I held for a great many years as a physician to the "Royal Infirmary for Diseases of the Chest," gave me an opportunity of instituting an analytical research on this subject not before attempted.

The plan adopted in the collection of the facts was very simple. The apothecary of the infirmary was directed, when he entered the name, address, age, and duration of illness of each patient, to add to the record, in the cases of all persons except children, the information whether they did or did not smoke. The apothecary had nothing to do in the matter of inquiry into the nature of the disease; that was left for me to determine, and as, during the greater part of the time in which the investigation was carried on, I saw, by rule, only six new patients per day, I had leisure to make myself sure of the precise nature of each form of disease that came before me.

The data thus obtained related to the two most prominent, and indeed to the

only two diseases of the chest that we need specially discuss, namely, consumption and chronic bronchitis.

The facts elicited by this inquiry are as follows:—

IN REGARD TO CONSUMPTION.

There came under notice cases of the total number of	361
Out of this total, there were persons who did not smoke,	225.
Persons who did smoke or had smoked,	136.
Thus, out of 361 consumptive persons, those who did not smoke showed an excess of	89.
Out of the total 361, there were, males,	230.
Females,	131.
Out of the 230 males, the number who smoked was	136.
The number who did not smoke was	94.
Thus out of 230 consumptive males, the smokers showed an excess of	42.

IN REGARD TO CHRONIC BRONCHITIS, INCLUDING ASTHMA.

There came under notice, cases to the total number of	475.
Out of this total there were persons who did not smoke,	338.
Persons who did smoke or had smoked,	137.
Thus out of 475 persons suffering from chronic bronchitis, those who did not smoke showed an excess of	201.
Out of the total of 475 there were males,	249.
Females,	226.
Out of the 249 males, the number who smoked was	137.
The number who did not smoke was	112.
Thus out of 249 males suffering from chronic bronchitis, the smokers showed an excess of	25.

It suffices to read the figures given above, to learn that neither consumption

nor bronchitis in the chronic form, can be induced primarily by smoking, for while it is true that amongst the male sufferers those who smoked were the most numerous from both diseases named, the circumstance is merely coincidental. Had the persons whose cases were recorded been in health, had they been passing before a recruiting sergeant for entry into military service, for instance, there would have been a similar comparison, in regard to numbers, between the smokers and those who did not smoke. I am obliged, consequently, to state that amongst the male sufferers from consumption and bronchitis, a small majority indulged in smoking. Taking the whole of the sufferers, fifty-seven per cent. were smokers, forty-three per cent. were not smokers.

It would, obviously, be false to this question to let it rest solely on the statistics derived from one sex, for women are as susceptible as men to the two diseases named. Here, then, is a touchstone. Are women, who as a body are not smokers, and men who are not smokers, if placed together as one class, less subject to these diseases than men who are smokers? We turn to our tables and find that the combined class is not less subject, and that on the large scale the luxury of smoking does not come into the list of causes at all."

From these statistics and remarks of Dr. Richardson, which embrace excessive as well as moderate smoking, it is almost conclusively shown that tobacco cannot primarily excite either bronchitis or consumption, and in connection with this might be mentioned certain instances in which tobacco is of benefit to the throat and lungs. Its efficacy in asthma is fully conceded by all. I, myself, have used it in four cases with the best results. Singers, who perhaps suffer more from throat affections than any other class of people, have learned from experience that the moderate use of tobacco renders them much less susceptible to colds and sore throats.

In conclusion, I wish to bring out a

fact in regard to tobacco, which is of more recent origin, and while it is not an argument for its harmlessness, it is at least a defense for its use.

Since the introduction and prevalence of the germ theories, and in the wide search for germicides and disinfectants, tobacco smoke has been experimented with by Mr. V. Tassinari, with good results. A piece of linen was dipped into a solution containing numerous microbes, and was then exposed to the fumes of cigarettes or a cigar. "The rag was then immersed in a vessel containing a liquid known to be favorable to the multiplication of the microbes. Repeated trials with various micro-organisms, contrasted the while with similarly prepared rags which had not been fumigated, showed that the smoke had greatly, and in some cases, altogether, destroyed the life of the organisms."

Dr. Hajeck, of Vienna, basing his researches on these experiments of Tassinari, looked up the vital statistics of Vienna, to see whether diphtheria is less prevalent among men, who generally smoke, than among women. He found that for the past four years the ratio of diphtheria cases in men to those in women was 1 to 2.8, or almost three times as many cases in women. This, he claims, bears out the experimental results of Tassinari.

Now may it not be possible that, by fumigating and disinfecting our throats and lungs with tobacco smoke, we are frequently protecting ourselves from diseases to which we are being constantly subjected, and are thus keeping our throats in a healthier condition than they would ordinarily be, instead of inflaming and diseasing them as is generally supposed.

Dr. Gärtner has been appointed Extraordinary Professor of General and Experimental Pathology at Vienna.

The Medical Society of Virginia will hold its twenty-first annual meeting at Rockbridge Alum Springs, beginning on September 2d.

THE DIAGNOSIS AND TREATMENT OF THE SIMPLER EYE DISEASES.

BY HERBERT HARLAN, A. M., M. D.,
OF BALTIMORE.

Assistant Surgeon Presbyterian Eye, Ear, and Throat
Charity Hospital, etc.

(Continued from page 347.)

Trichiasis or Wild Hairs is the condition where the cilia do not grow in the usual way, but from one cause or another grow irregularly, and in so doing scratch against the cornea and thus often produce much irritation and at times very serious impairment of vision. The diagnosis is very easy, provided the eye be carefully examined. Sometimes only a single hair is at fault and again all the lashes may turn inward. This latter condition must be distinguished from *entropion* where the margin of the lid itself is inverted, of course carrying with it the lashes and so producing much irritation to the eye.

In trichiasis, when only a few hairs scratch the cornea, they may be pulled out with a pair of tweezers. Rarely, this is sufficient. Usually in two or three weeks the hairs grow again and have to be again pulled out. Some patients who have still good vision get quite expert and can take very good care of themselves pulling out the cilia whenever they become troublesome. Or some member of the family can, after some little instruction, do the epilation quite well.

When it is advisable to destroy the hairs permanently there are several special operations for the purpose. The method by electrolysis is the one I have found most satisfactory. It is quite painful, however, and not many patients will submit to the destruction of more than a few hairs without an anæsthetic. Where a great many hairs or the whole lid border turns in (*entropion*) the condition is much more serious and the radical operation for its relief scarcely comes within the scope of this article. The most fre-

quent cause of trichiasis is a neglected blepharitis or catarrhal conjunctivitis.

Ectropion is when the eyelid is everted, and when not caused by the loss of the skin of the eyelids from wounds, burns, etc., is due to trouble with the lachrymal apparatus and will be briefly discussed under that head.

Pediculi or. Lice.

An interesting, though not very common affection of the eyelids or rather of the eyelashes is the intense itching and irritation caused by the presence of pediculi pubis on the cilia. Again a careful examination makes the diagnosis easy.

The variety is the same as is found on the hairs of the genitals. Close inspection shows the lice and especially the eggs firmly attached to the cilia. One or two applications of mercurial ointment, or better of the yellow oxide ointment, readily destroys all the living pediculi but not the eggs, though a cure is easily affected by continuing the application of the ointment and so destroying the lice as they develop. The eggs are so firmly glued to hairs that it is with great difficulty they can be separated, and if one is seized with fine forceps the lash will always be pulled out before the egg is separated from it,

Ptosis

Paralysis of the levator palpebrae produces a dropping of the upper eyelid and an inability to open the eye. This affection is frequently congenital but often also accompanies more or less complete paralysis of the third nerve, sometimes only the filament supplying this muscle is involved, but usually the other branches of the motor oculi share in the disturbance. On opening the eye the pupil is found dilated and the eyeball everted. I have seen several cases where the ptosis or drooping of the lid was secondary to a diplopia produced by paralysis of some of the recti muscles, and where to get rid of the annoyance of double vision the patient began closing one eye and after a few days the eye remained closed. In other words nature shut up an eye where its use produced annoyance. In most cases

this was perhaps merely the extension of the lesion. One, however, I recall where the diplopia was produced by paralysis of the external rectus, and it is not easy to trace the connecting link in that case between the distinct nerves supplying the two muscles. A number of operations have been devised for the relief of ptosis, but it must always be borne in mind that a large percentage of the cases of paralysis of eye muscles are of syphilitic origin and must be treated accordingly.

In paralysis of the orbicularis palpebrarum the eye cannot be closed. This may be more or less complete and in the more severe form is quite serious from the effect produced by the constant exposure to light and irritating foreign bodies of one sort and another.

The punctum is also everted and there is constant lachrymation.

The lesion may be central or anywhere in the course of the facial nerve; a frequent location is in the aqueductus Fallopii. These paralyses of the 7th pair of nerves vary much in the extent of the trouble produced. Sometimes the orbicularis escapes entirely and sometimes it alone of the face muscles is affected. Among the causes are exposure to cold and damp, suppurative disease of the middle ear, tumors, haemorrhage, etc., at the base of the brain. Again, very many cases can be traced to syphilis and must be treated accordingly. Mild cases due to exposure often get well in a few days without treatment.

(To be continued).

The census taking in New York has developed the fact that more than sixty languages and dialects are spoken in that city.

Professor Schmidt-Rimpler, of Marburg, has been appointed to the Professorship of Ophthalmology at Göttingen, vacated by Professor Leber, who has gone to Heidelberg. Professor von Hippel of Königsberg has declined the invitation to come to Göttingen.

Society Reports.**WASHINGTON COUNTY MEDICAL SOCIETY.**

STATED MEETING HELD AT HAGERSTOWN,
MARYLAND, AUGUST 13TH, 1890.

Dr. N. B. Scott of Hagerstown in the chair.

The third annual meeting of the Washington County Medical Society was called to order on Wednesday afternoon, August 13, 1890.

Dr. T. A. Ashby of Baltimore read a paper on

SALPINGITIS.

Dr. J. W. Humrichouse of Hagerstown reported

TWO CASES OF SUFFOCATIVE GOITRE.

Dr. J. H. Koons of Ringgold discussed

AUTOPSIES.

Dr. A. S. Mason of Hagerstown reported

A CASE OF RESIDUAL URINE.

Dr. V. M. Reichard of Fairplay, read a paper on

PERFORATION OF THE VERMIFORM APPENDIX.

Dr. W. M. Nihiser of Keedysville, reported a case of

CEREBRO-SPINAL MENINGITIS.

Dr. J. E. Pitsnogle of Sharpsburg, read a paper on

PUERPERAL ECLAMPSIA.

There was some some spirited discuss-

sion of these papers. Most of these papers will be printed in full in the MARYLAND MEDICAL JOURNAL.

The society has now upon its roll of active members the following physicians: Of Hagerstown, Drs. N. B. Scott, James B. McKee, Wm. Ragan, T. W. Simmons, A. S. Mason, J. McP. Scott. O. H. W. Ragan, E. M. Schindel, H. K. Derr, S. M. Yancy, C. L. G. Anderson and J. W. Humrichouse, Dr. E. Tracy Bishop, of Smithsburg; Dr. J. M. Gaines. Dr. H. McGill Wade and Dr. C. W. Wheeler, of Boonsboro'; Dr. A. G. Lovell, of Benevola; Dr. T. Eliason and W. H. Perkins, of Hancock; Dr. H. S. Herman, of State Line; Dr. J. M. Steck, of Chewsville; Dr. C. D. Baker, of Rohrersville; Dr. W. M. Nihiser, of Keedysville; Dr. Abraham Shank, of Clearspring; Dr. S. Howell Gardner, of Sharpsburg; Dr. Jno. H. Koons, of Ringgold; Dr. Henry U. Onnderdonk, of St. James' College; Dr. J. H. Wishard, Leitersburg; Dr. V. M. Reichard, Fairplay.

After some routine business and the election of new members, the society adjourned to meet the second Wednesday in November at 10 o'clock A. M.

J. W. HUMRICHOUSE, M. D..

Corresponding Secretary,

Hagerstown.

The *Medical Record* says:—Dr. Charles T. Montgomery, of Glasco, N. Y., a typical general country practitioner, who is the popular physician for a wide district, drove in an ordinary buggy one hundred and seventy-three miles in forty continuous hours without rest save at meals. During this time he saw sixty patients and used only four horses for the work, driving them in pairs. Very few, if any, practitioners can equal this, and yet very many of our good friends in the country of large business have similar strains upon their endurance. Who can beat this record?

MARYLAND MEDICAL JOURNAL**Weekly Journal of Medicine and Surgery,****WILLIAM B. CANFIELD, A.M., M.D., Editor***Subscription \$3.00 per annum, payable in advance.*

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BALTIMORE, AUGUST 30, 1890.

Editorial.**PYROSIS OR WATERBRASH.**

(Paroxysmal Salivary Discharge).

These names, Pyrosis and Waterbrush, have heretofore been applied in a loose way to two distinct affections. The first, a regurgitation of a sour liquid gastric juice—generally accompanied by a burning sensation in the stomach or fauces, to which no further reference need be made at this time. The second affection is characterized by the discharge from the mouth of a thin watery alkaline fluid, in large quantities. The nature of this latter disorder is discussed by Dr. Carter in the *Practitioner*, May, 1890. It may be defined as a paroxysmal condition, generally beginning with more or less severe

pain in the epigastrium, and resulting, after an uncertain interval, in the discharge from the mouth, without nausea or straining, of a clear fluid varying in quantity from a spoonful to more than a pint. The pain in the epigastrium is variable in intensity, increased by movement, especially in the erect posture, and often relieved for a time by complete rest and by relaxation of the abdominal walls. The fluid is not discharged by vomiting, but at most only by a sort of regurgitation from the throat. It is thin and of a mawkish taste containing only a few granular cells and some squamous epithelium. It darkens on the addition of ferric perchloride and has the power to change starch into sugar, resembling in these particulars saliva. The discomfort of this discharge may lead to vomiting, and at times gastric juice is mixed with the fluid, yet these two conditions are not essential to the disorder under discussion but are merely accidental complications.

The disorder rarely occurs before puberty. According to Dr. Carter the cases may be classified into three groups:

1st. those in which there is no stomach trouble present and the paroxysms are not the result of the ingestion of certain articles of food; the subjects are generally nervous women, especially such as are pregnant or affected with pelvic troubles or some other diseased condition which excites reflex nervous action; and the initial pain about the stomach may in these cases be quite absent.

2nd, those in which, whether stomach disease is present or absent, the paroxysms are due to the ingestion of some offending article of food, as oat-meal, rye-bread, smoked fish, etc.

3rd, those in which disease of the

stomach is present, as chronic gastric catarrh with dilatation. Dr. Carter relates a case of this class, the patient having dilatation of the stomach, in which the paroxysms came on generally toward evening. Soon after the onset of the pain there would be a gush of clear tasteless fluid from the mouth, the discharge lasting sometimes for four hours and amounting to nearly a pint. There was no nausea nor effort, but if the patient lay on the side it would dribble from the mouth and if he lay on the back it would run down the throat and be swallowed. Sometimes the attacks would pass away without other symptoms. Generally, however, they would end with nausea, eructations and true vomiting, with discharge of a large quantity of very acid, frothy, sanguinous vomit. The patient was greatly relieved by treatment.

It seems evident from the above considerations that the disorder consists in a paroxysmal discharge of saliva, which flows directly from the mouth or collects in the fauces or oesophagus and is thence regurgitated. The paroxysms depend on a peculiar sensitive condition of the nervous system, and are immediately excited by some irritation of the stomach or pelvic generative organs (perhaps at times of other organs). There is no disease of the salivary glands themselves. The pain is sometimes due to flatulence.

Treatment must be adapted to the peculiar needs of each case. Opiates are much used, but unless combined with belladonna are apt to constipate and disturb digestion. They are sometimes very useful in small doses in the purely nervous cases. Exciting causes should if possible be removed. The digestive tract may be soothed by irrigation of the stomach (the tube being best lubricated

with milk) or by the use three times a day of sodii bicarb. grs. x, sodii phosphat. 3*i*, in aromatic water or in a mild vegetable bitter, given an hour before meals, with an aperient dose of Carlsbad Sprudel salts every second morning. The diet should consist of milk, diluted at the time of administration by an equal quantity of hot water, and containing in each pint of milk sod. bicarb. grs xx. sod. chlorid. grs xx magnesiæ levis grs. x.

IS SMOKING IN MODERATION INJURIOUS TO HEALTH?

In this issue Dr. Norton of Washington asks if smoking in moderation is injurious to health. There are very few virtues or vices which, if used in moderation, are injurious to health. In this country, where limits are more extended and ideas broader, one does not hear of the "anti" societies as in England.

Smoking in moderation is a very pleasant occupation, and as is stated in the article, a quiet smoke after a hearty meal is more conducive to good digestion than the most highly vaunted brand of pepsin. The occupation of smoking tends also to concentrate thought on a subject, and many a literary man can do no work, or no good work, with unlighted pipe or cigar.

The great danger of smoking, as of every other so-called vice, is that it can rarely be indulged in, in moderation, and by the "pious" it has been ranked with drinking—company which it does not deserve. The bactericidal effect of tobacco may be worth considering, but it sounds very much like the happy thought of a theorist.

Correspondence.**BERLIN LETTER.**

BERLIN, August 9th, 1890.

Editor Maryland Medical Journal:

DEAR SIR:—According to my promise I will send you a short account of my sojourn in Berlin as a member of the Tenth International Medical Congress. As you know I left New York on the 24th of July, on the "Augusta Victoria" in order to make the ocean trip as fast as possible. Among the two hundred first cabin passengers there were about fifty physicians from different parts of North and Central America, some alone, and some in company with their families, so that even on the steamer, the conversation had a medical tone. My travelling companion was Doctor Lustgarten, the discoverer of the syphilis bacillus and formerly *privat-docent* at the University of Vienna. His paper at Berlin which he read in the Section on Dermatology on a new disease, the so-called psorospermosis, excited considerable interest.

At Southampton, several very distinguished English physicians came on board, among whom were Dr. Stokes and Sir William MacCormac, and also Dr. Parvin of Philadelphia. On the 2nd of August, I arrived at Hamburg, and on the same day went to Berlin. On the train I happened to sit in the same coupé with Dr. Parvin and was much pleased to make the personal acquaintance of this celebrated obstetrician.

On arriving at Berlin I found it very difficult to obtain a place in a hotel; indeed, the Hotel Central with its five hundred rooms was completely filled; but, after long searching I found a place in the Hotel Kronprinz near the Charité and the Ausstellungsplatz.

Although I know Berlin very well and it always makes a vivid impression on me, I was struck with the number of dis-

tinguished foreigners, many of whom belonged to the nobility, and who conversed in every conceivable tongue, and had travelled immense distances, in order to participate in this great scientific exchange of thought.

But first I should like to say to you that my greatest expectations of this most important affair were far exceeded by the reality. On the day of my arrival in Berlin I visited my friend Dr. Lassar, the Secretary of the Congress, and there had the honor of meeting Virchow, who greeted me most kindly as an American colleague. On Sunday evening there was a magnificent private reception at the house of Dr. Lassar, who has a very handsome residence on the Reichstagufer, and to this entertainment several hundred guests were invited. Luxury and hospitality were the crowning features, and I shall never in my life forget this beautiful evening. There I had the pleasure of meeting many medical celebrities, among them especially Kaposi, with whom I had the honor of conversing for some time. I was very much astonished to find so few Baltimore physicians, while the New York physicians were there in large numbers.

On Monday the 4th of August, at eleven o'clock in the morning, the first meeting was held in the Circus Renz. This was the opening of the Congress, and I cannot help saying that I have never seen this enormous building filled with such a distinguished audience. There were about five thousand physicians and one thousand ladies present.

Amidst loud applause Virchow stepped upon the platform accompanied by Waldeyer and Bardeleben and welcomed the guests who were present. He emphasised particularly the international character of the Congress, he designated medicine as a popular science, and extended special greetings to the French guests, who were present in large numbers. He stated that the object of this Congress was exclusively a scientific one, and that the whole body of physicians

stood in the front ranks of struggling humanity. Then the general secretary of the Congress, Dr. Lassar, made his report, and mentioned that besides 2,500 German physicians and many from other countries, there were about 500 American physicians present, which communication was received with loud applause. Then he announced to the great assemblage that the celebrated American, Edison, through a representative, would demonstrate a new method of treatment, by which it would be possible to cause a destruction of calculi by electro-mechanical means.

In the name of the German government, and at the command of the Emperor, State-secretary von Bötticher spoke, and emphasised especially the separation of science from politics. Minister von Gossler extended in the name of the Prussian government a greeting to the Congress, and the mayor of Berlin, Herr von Forckenbeck, also welcomed them in the name of the city.

The general secretary of the last Congress held at Washington, Dr. J. B. Hamilton, spoke so low, that although I was sitting very near him I could not understand a word he said. As Sir James Paget stepped upon the platform there arose such a storm of applause that it was several moments before it was quiet again. He thanked the assemblage in the name of the English people for his warm reception.

After him the Frenchman, Dr. Bouchard, spoke, and the Italian, Baccelli, and the latter used the most classical Italian, and reminded me very vividly of Salvini. I might mention here that he was elected president of the next Congress. The next afternoon the English sections were formed, but it would be impossible for me to report the work of each section. Especially interesting was the discussion on "Vaginal Extirpation of the Uterus," in which Ohlshausen, Martin, Kaltenbach, Pozzi, Péan, and Landau, took part. Although there were many different opinions expressed on the methods of the

operation and the aftertreatment, still all agreed on one point, that in every case of carcinoma uteri, if the operation can be done at all, the total extirpation of the uterus should be considered. Then a case was mentioned in which the high amputation had been done for a small cancerous nodule, and after ten years there was a fatal relapse, consequently we should never speak of cured cases, even though two or three years have elapsed without a return. In the discussion on "Antisepsis in Obstetrics" Dr. Parvin of Philadelphia spoke, and the general opinion was that in normal births, all antiseptic treatment after delivery was superfluous, indeed dangerous. On Wednesday the 6th of August in the Circus Renz the second general session was held, in which Herr Virchow announced that the number of participants in the Congress was now 5566, of which 623 were Americans, 421 Russians, 351 English and 179 French. Rome was decided as the next place of meeting. Before I close, not to write too long a letter, I should like to tell you something about the reception at the Rathhaus, which the city of Berlin gave to the visitors on Wednesday, and I can assure you that I never attended such a grand entertainment in my life. I must confess that the city of Berlin knows how to entertain its guests, and put both young and old in a jovial humor. General happiness reigned and there was great freedom from restraint, and the politeness with which the German physicians received their foreign guests was touching. I shall have the pleasure of writing to you again soon.

Yours very truly,

ROBERT HOFFMAN, M. D.

When a woman conceives and has twins, one being white and the other a negro, it is evident that the fact of superfœtation has been proved in black and white.

Reviews, Books and Pamphlets.*Diseases of the Rectum and Anus, Their Pathology, Diagnosis and Treatment.*

By CHAS. B. KELSEY, A. B., M. D., New York, Professor of Diseases of the Rectum, at the New York Post-Graduate Medical School, etc. Third edition, rewritten and enlarged, with two chromolithographs and 168 illustrations. New York: Wm. Wood & Co. 1890. Pp. 479. Price \$4.00.

The third edition of this valuable work has been almost entirely rewritten, and is much larger than the former editions, which we have already noticed in these columns. Much new matter has been added on the treatment of stricture, both benign and malignant, and on the formation and closure of artificial anus. While diseases of the rectum and anus can hardly be studied from a text-book, the use of such a book as this with the large number of excellent illustrations, both plain and colored, will be of great use to the surgeon.

Reformation in the Practice of Medicine by the Dosimetric Method of Practice, or the Method of Small Doses of the Active Principles of Plants, Mathematically Measured and Scientifically Adapted to the Varied Abnormal Conditions. By Dr. J. E. MACNEILL, Denver, Col. With Biographical Sketch of Dr. Ad. Burggraeve. Reprint. 1889.

Dosimetry in Colorado. By DR. J. E. MACNEILL, Denver, Col. 1890.

Five Cases of Vaginal Hysterectomy for Malignant Disease of the Uterus: All Recovered. By W. F. McNUTT, M. D., L. R. C. P., Ed., etc. Reprint. 1890.

A Louisville doctor, aged eighty-one, has just married his sixth wife, aged forty-one.

Miscellany.**CURE, NOT PUNISHMENT.**

(What Dr. Morris will recommend to the National Prison Association.)

Dr. John Morris, who has made a study of the reformation of prisoners, is preparing a paper to be read at the meeting of the National Prison Association in Cincinnati next October. Dr. Morris takes for his theme in discussing such matters, "Cure, Not Punishment, for the 'Bummer' and Chronic Inebriate," and the paper will recommend his plan of cure to all the large cities of the United States. The Doctor referred to his statement made about two years ago in the State Medical Faculty, during a discussion on the cure of inebriety, that no cure for inebriety could be effected unless labor was used as the principal means, and that the reason so few cures were made in inebriate asylums, was because the inmates of these institutions were egoists and idlers, who spent their time in smoking pipes and reading novels and other trashy literature.

At that meeting he suggested a plan of cure for the thousands of the drunkards called "bummers," who are committed and recommitted yearly to the city jail, and said that a sanitarium in which labor would be the principal element of reform and rehabilitation should be established for the care of these unfortunates, and that he thought the city should apply to the general Government either for the gift or the purchase for a small sum, of Fort Carroll, which would answer admirably for the purposes needed.

"Fort Carroll," the Doctor said, "is a perfectly useless piece of property, and has been for years an expense and care to the Government. It would be necessary, in addition to this, for the city to purchase a few hundred acres of land in conjunction with the fort for a truck farm, which could be worked profitably for the patients. It would require but

a few armed guards to prevent escapes, as is now the case at the House of Correction at Bridewell. Those 'patients' not engaged on the farm or other outdoor work, could be employed in mechanical industries that would not interfere or come into competition with the labor of honest mechanics outside of the 'sanitarium.'

"This plan, however," says Dr. Morris, "would be utterly useless unless it were coupled with the indeterminate sentence law—a law which works so admirably in some of the states, notably in New York and Ohio. The indeterminate law is not at all known or understood by our people. It is a probationary system, which provides for the discharge of the inmate as soon as he is fitted to go back to the community—in a word, when he is healed, cured; and of this, the managers of the sanitarium or reformatory are to be the judges. When the man is committed by the court he is not sentenced for any given time. He may remain one week, one month, one year or even for life, if in the judgment of the managers of the reformatory he is still a 'leper.' A highly useful and beneficent feature in the indeterminate law is that of probation. If a person sentenced shows decided proofs of reformation, he is allowed to go out into the community on trial, being only required to report himself at stated times. Should he relapse, he is *again committed*, sent back to the reformatory without trial or expense to the city, inasmuch as he never had been discharged. The great necessity for this change in our criminal management will be apparent when we reflect that out of the 11,740 commitments last to the city jail of Baltimore, 8,782 were committed for drunkenness and disorderly conduct. More than one-fourth of this number were habitual offenders, and spent from three to nine months of every year in the prison.

—*Sun.*

[In conversation with Dr. Morris since the above was published, he stated that

he had overlooked a very important part of his plan, *i. e.*, the utilization of the whole sewage of the city on the farm. He says that by the labor of the "patients" the sewage could be converted into a compost, which would sell readily at a good price. He is indebted, he says, to Dr. Rohé for this suggestion. In addition to the other advantages of Fort Carroll, Dr. Morris says, the city authorities have long considered it as the best site near the city for the quarantine station.—ED.]

IODOFORM AND CREASOTE AS AN INHALATION IN PHthisis.

The following inhalation is recommended by Brunton in the treatment of phthisis:

P.	—Iodoform	24 grains.
	Creasote	4 minims.
	Oil of eucalyptus	8 "
	Chloroform	48 "
	Alcohol } equal parts to make $\frac{1}{2}$	
	Ether } ounce.	

To be used in a Robinson's inhaler.

—*Virginia Medical Monthly*, August, 1890.

TREATMENT OF TYPHOID FEVER BY COLD BATHS.

M. Debove, in a paper read at the last session of the Paris Société Médicale des Hôpitaux on the treatment of typhoid fever by cold baths, declared that he had not been convinced by a recent paper of M. Merklen that this was the best treatment. His own mortality during the last six years was 11 per cent., or during the last two years 9.2 per cent. Now M. Merklen estimates the mortality from typhoid in Paris hospitals treated by cold baths as 9.92 per cent. M. Debove does not prescribe active medication, but believes in keeping up copious diuresis. To this end he supplies his typhoid patients with abundance of liquid, and if the quantity of urine passed does not appear to him sufficient, he "stimulates the

zeal" of the attendants to get the patient to drink more; the total amount of fluid which should be taken daily ought, he says, to be not less than five or six quarts. M. Debove, who does not deny the good effects of baths, suggests that they are probably due to the increased quantity of urine secreted, which, as in the case where diuresis is produced by drinking, carries off the *materies morbi* from the system. According to M. Gérin-Rose, who followed M. Debove, still more successful results may be obtained by carrying out the following indications: (1) To produce intestinal antisepsis by means of naphthol and salicylate of bismuth, (2) to lower the fever by means of very large doses of quinine and warm baths (at 86° F.), and (3) to keep up the patient's strength. Of forty-three patients treated during the last eighteen months in this way only one died.—*Lancet*.

LATENT CHRONIC GONORRHœA IN MAN.

Dr. Ernest Finger, in article which is concluded in No. 7 of the current Wiener mediz. Wochens., says we have three forms of chronic blennorrhœa:

1. The recent forms, in which, along with the circumscribed areas of disease, there are still more surrounding tracts of congestion and passive hyperæmia, with softening, swelling, and hypersecretion of the mucous membrane. These forms show themselves in the urine, being clouded by mucus and containing gonorrhœal threads.

2. Older circumscribed forms with gonorrhœal threads in clear urine, but in which the changes are superficial, and have their seat only in the mucosa.

3. Similar forms in which, however, the changes go deeper and affect the mucosa, submucosa; in the pars anterior, a portion of the corpus cavernosum; in the pars posterior, the prostata, the caput gallinaginis, and the prostatic glands.

According to the form and location thus indicated, the author lays down certain precise indications for treatment.

I. In the first form we have the con-

comitant catarrhal symptoms to combat, and hence apply directly to the diseased parts dilute, weak astringent solutions. First of all, the catarrh is to be cured, then the deeper areas will alone remain.

II. In the second form of circumscribed mucous areas of disease we must resort to strong astringents and caustics applied to the most limited regions possible.

III. In the third form we have, along with the superficial indications to meet, a deep effect which must be produced by pressure and resorbents. When the catarrhal inflammation of acute urethritis affects the posterior part of the canal the whole urethra must be washed out. For this purpose the author prefers Diday's irrigation to Ultzmann's irrigation catheter.

Diday's method consists in passing a Nélaton catheter into a partly filled bladder and, when the urine begins to flow, to gently withdraw the instrument until the flow ceases. The eye of the catheter lies then in the posterior part of the prostatic portion. A syringe is now filled with the astringent to be used (preferably warmed) and the nozzle inserted in the external end of the catheter, and as the latter is slowly drawn out the lotion is injected. For this purpose permanganate of potash (1 to 5,000), sulphocarbonate of zinc (1 to 5,000), or nitrate of silver (1 to 1,000), may be employed and renewed every second or third day. The secretion of the mucous membrane will disappear, but the urine will still contain flocculi, and we have the second form before us. The localization of the diseased part can be determined by the sound, which always produces pain in the same point, located in the bulbous or prostatic part. The indication is to apply remedies exactly to the affected area. Nitrate of silver and sulphate of copper can be used in from $\frac{1}{10}$ to 10 per cent. solution.

Lanoline salve is highly recommended as not being so readily washed away with the act of urination.

He uses creolin, 1 to 3; or nitrate of

silver, 1 to 3; or sulphate of copper, 1 to 5 parts; lanoline 95, and olive-oil 5 parts. This is applied every second or third day by means of a Tommasoli-syringe. In the third form Otis's sounds Nos. 24 to 30 are recommended left in the canal from 5 to 15 minutes, followed by the above-mentioned astringent lotions or salve, or the following:

R. Kali iodidi	5.0;
Iodi puri	0.5 to 2.0;
Aq. dest.	100.0.

The value of the endoscope, whose worth is unquestioned, is not discussed.—*Journal of Cutaneous and Genito-Urinary Diseases.*

THE QUESTION OF HÆMORRHAGE AFTER OPERATIONS.

One of the chief factors contained in the prognosis of any surgical operation is the question of hæmorrhage, and the extent of the latter will depend upon the nature of the operation, and the age, sex, and constitutional state of the patient. As is well known, loss of blood is accompanied by a corresponding decrease of the number of red blood corpuscles and a reduction of the quantity of hæmoglobin. If, therefore, by means of the hæmometer we estimate the quantity of hæmoglobin before and after an operation, we can form an approximate idea of the extent of the hæmorrhage.

This has been recently attempted by Prof. Mikulicz, the results of whose investigations are formulated in a paper read before the late Congress of the German Surgical Society. Dr. Mikulicz has examined the blood of four hundred persons at various periods before and after operations, making altogether four thousand examinations. These revealed that the largest quantity of hæmoglobin is present in the blood between the ages of twenty and thirty years, while in children under ten years it is at a minimum. In females the quantity is less than in males at all periods of life.

An interesting part of these investigations is that relating to the time required for the regeneration of the hæmo-

globine after hæmorrhages, the rapidity of its formation depending, of course, upon the severity of the hæmorrhage. The most rapid reproduction was observed in young men, the average time required being ten days, while in aged females it was prolonged to three times this period. The old observation was confirmed that children and aged persons are more seriously affected by losses of blood than individuals of middle age. In general for every five per cent. of hæmoglobin lost five days of regeneration were required. As regards the maximum loss of this element which patients were able to survive, it was noted that a reduction of twenty per cent. was always followed by a fatal result. As might be imagined, the quantity of hæmoglobin was always found considerably reduced in persons suffering from tuberculosis, and the period of regeneration after operations was always six or eight days longer than under normal conditions. The same was observed in cases of syphilis, actinomycosis, and malignant tumors, while benign growths which did not react on the general health were without influence. It is also a curious fact that the prolonged administration of chloroform in operations unattended with loss of blood produced a decrease of the hæmoglobin.

The author thinks that the knowledge gained by a large number of observations of this nature may prove of inestimable value to the surgeon. For, if it is possible to determine the minimal quantity of hæmoglobin necessary to sustain life in persons of different age, and suffering from various diseases, and to estimate the amount of loss in different surgical procedures, we will be able to decide with mathematical certainty whether the patient is at any given time in a condition to survive an operation.—*International Journal of Surgery.*

SPRAINS OF THE ANKLE.

Dr. Reclus, a hospital surgeon in Paris, has recently published an account of a method of treating sprains or subluxa-

tions of the foot, which is referred to in the *Medical Record*, July 19th, 1890. The treatment is a mixed method, founded on the employment, successively of an elastic bandage, hot foot baths and massage. As soon as the sprain is produced, the region affected should be enveloped with an elastic roller, the application of which should be commenced at the roots of the toes, and it should be rolled round the foot, on the instep and about midway up the leg; it should be tightened just sufficiently for the roller to be kept in place. When the sprain is not very severe, slight movements may be permitted. Twice a day, morning and evening, the elastic bandage should be removed to wipe and dry the parts, as under the impermeable tissue there accumulates sweat which soon decomposes, assumes an insupportable odor, and, what is more serious, irritates the integuments. Without this precaution it might provoke eczematous, and even furuncular, eruptions. It is then that the second precept of the treatment should intervene. The affected joint should be plunged into a bath the temperature of which should be progressively raised until it attains 48°. 50°, and even 55° Centigrade. Under its influence the pain ceases, if the elastic bandage had not already dissipated it, the circulation is increased, and perhaps also the nutrition changes. These divers modifications have probably a great deal to do in the more rapid resorption of the peri-articular exudations. It is also to promote resorption that massage is added to the pressure of the elastic roller, and this massage constitutes the third part of this mixed treatment. The elastic roller has certainly the advantage over massage in acting in a continued manner, but it cannot, like massage, expel from the meshes which contain them the solidified clots, for which purpose the strong pressure of the finger, "petrissage," would not be too much. After the immersion of the foot in hot water for ten or fifteen minutes, and after a séance of massage from ten to

fifteen minutes, the limb is enveloped for twelve hours in the India-rubber bandage. The author observes that the sprain must be very severe if complete cure is not obtained in less than fifteen days.—*Medical and Surgical Reporter*.

SUPPOSITORY FOR CYSTITIS.

R.—Iodoform	2 grains.
Extract of belladonna	$\frac{1}{2}$ grains.
Cacao butter	45 grains.

Pass this well into the bowel, and morning and night inject into the rectum hot water. If any inflammation of the urethra occurs or is present 1 grain of terpine or salol may be given in pill twice a day.—*Medical News*.

SIMPLE METHOD OF CURING OBESITY.

A French journal announces a cure for obesity which is as simple as it is said to be effective (*Weekly Medical Review*). The method consists in never eating more than one variety of food at a meal, without any restriction in the amount taken. Two cases are reported illustrating the effects of the treatment.—*Medical News*.

PRESERVALINE.

In the bright lexicon of commerce this is the name of one of a number of preparations sold to milk-dealers to enable them, by adding it to their milk, to palm off stale milk on the community. It is supposed to consist mainly of boric or of salicylic acid. Ten per cent. of the milk furnished by dealers supplying Brooklyn is said to have had one of these substances added to it. The persons concerned profess that the milk is not made injurious by this procedure, but it is very obvious that it may become injurious under certain circumstances, and the State Dairy Commission is quite right in declining to leave that question to the milkmen's discretion. Certainly the community has a right to be protected from surreptitious drugging.—*New York Medical Journal*.

A MERITORIOUS ACT "TO PREVENT BLINDESS."

The State of New York has taken a step in the right direction by passing a law requiring midwives to report to a physician or health officer all cases of ophthalmia observed by them in infants. With proper co-operation on the part of physicians there should be a decided reduction in the number of blind in that State; and not only will individuals be benefited but communities throughout the State will have financial burdens lifted from them. New York had in 1880, 5013 blind inhabitants, of whom at least 500 were blind from ophthalmia neonatorum, the disease which this act seeks to prevent. The cost of supporting one blind person in an economical manner has been estimated at \$132 annually (\$2 per week for board, \$28 for clothing). This estimate would make the cost of supporting 500 blind people, \$66,000 annually. But as the blind are consumers and not producers, the community loses the earnings of as many individuals as it has blind inhabitants. Estimating a man's wages at \$1.20 for each working day, and counting the wages of a woman at 40 cents a day, there is a yearly loss to a community for each man \$404, and for each woman \$256. And this for New York means than \$1,5000,000 annually lost from the 500 blind referred to. It is too much to hope that blindness from ophthalmia neonatorum will disappear altogether from the passage of this act, but that it will be very greatly diminished is beyond doubt. And it is possible that the future will see, through legislative acts, and active co-operation in the medical profession, entire removal of this prolific cause of blindness. Now that New York has set the example, other States should follow it. Will not Tennessee fall into line and mark her progress and enlightenment by passing a similar act? If the profession could be brought to see the importance of this subject, there would be concerted action in their ranks, and legislators would not

be slow to recognize its import—for every community in the State would be benefited, both financially and socially, by any act that would prevent blindness. The apathy which prevades the profession on this subject is difficult to understand. As humanitarians we should interest ourselves to lessen the number of sufferers from blindness; and as economists, we should interest ourselves to remove to some extent, the burden of an army of blind people from our communities and our State,—*Memphis Journal of Medical Sciences*.

METHOD OF REDUCING DISLOCATION OF THE JAW.

Dr. Gerin, in a case of unilateral dislocation of the jaw, employed the following method. The patient, being seated, the physician stands behind him, and with the left hand placed on the patient's forehead, he fixes the head firmly against his chest. A compress folded to several thicknesses is placed over the lower teeth on the affected side. The surgeon then introduces his thumb between the dental arcades in such manner that the palmar surface of the thumb rests upon the molar teeth, while the other fingers grasp the horizontal portion of the lower jaw. Then bending a little forward over the patient he presses on the maxilla, combining with this downward pressure a slight backward movement. Almost immediately the bone is returned to its articular cavity.—*Bulletin Général de Thérapeutique*.—*Canada Medical Record*.

PENETRATING WOUNDS OF THE ABDOMEN.

From a report on Penetrating Wounds of the Abdomen presented to the Chilian Medical Congress, and printed in the *Revista Médica de Chile*, it would seem that the author, Dr. Barros Borgoño, has some cause to congratulate himself on his plan of treating such cases, as a rule, in an expectant manner—that is to say, without operation, but with ice and opium and no food. Eight were cases

of revolver wounds, of which four recovered and a fifth lived for seven months, dying ultimately of tuberculosis. In two of the cases that recovered there was some doubt as to whether there was perforation, but in the remaining six there was no room for doubt. In one of the cases in which recovery occurred the stomach was wounded; in another the colon was wounded from behind. Forty-six penetrating wounds of the abdomen by a sharp instrument are tabulated. Of these, thirty-one, or 60 per cent. recovered.—*Lancet*.

SUBBENZOATE OF BISMUTH IN THE TREATMENT OF SOFT CHANCRE.

A recent issue of the *Medizinisch-chirurgisches Central-Blatt* contains an article by Dr. E. Finger, of Vienna, in which are given the results of his therapeutic endeavors with subbenzoate of bismuth as a topical application in the treatment of soft chancre. The compound is described as being made by heating nitrate of bismuth with potassium nitrate and sodium benzoate. The precipitate, subbenzoate of bismuth, is collected on a filter, washed with water and alcohol, and dried. The author reports its use in sixteen cases. Some stinging sensations follow its application, but these are not severe. Six or eight applications were sufficient to secure a healthy surface, the dressing being made twice in twenty-four hours. Dr. Finger seems to consider the subbenzoate a valuable substitute for iodoform and the more violent cauterizing drugs where they are contraindicated.—*N. Y. Medical Journal*.

SUGGESTION FROM THE DRUGGIST TO THE DOCTOR.

Only the other day I saw a very expressive sentence which read: "Why does my family physician own a \$500 piano and a \$20 microscope?" I did not get his answer, but my own would be: "I don't know." Furthermore, I do know—he would not be my family physician. I do not think I would want a physician

who did not read enough or have at least curiosity enough to use a microscope in his diagnosis. It does not strike me as a compliment to hear "Dr. _____ is so busy with his large practice that he does not get time to read his journals at all." It seems quite disproportionate, and he better let some other doctor have a few of his patients, while he goes home to find out that the earth has revolved a few times since his day. The fact is, a physician cannot be abreast of the times without a microscope, or at least the use of one. My old professor in medicine used to give us as advice: "Gentlemen, as you go out into practice get you, first a horse, and second a microscope, and last a wife." —Prof. C. P. Pengra, M. D., in *Pharmaceutical Record*.

TREATMENT OF TUBERCULOSIS WITH BORACIC ACID.

For the past five years, Dr. Gaucher of Paris has been studying the action of boracic acid on pulmonary tuberculosis. He has recently made public the results which so far have accrued from his researches. He first of all determined by means of experiments on animals the toxic limits of the acid when administered internally, and he found that this stood at the ratio of about a gramme to a kilogramme of the animal's weight. As to its subsequent elimination from the system, he found that this took place very readily and even rapidly by way of the renal secretion; there was therefore little fear of any accumulation or tardy cumulative action. But, what was an equally important and desirable result, he found that the boracic acid was also eliminated appreciably through the expectoration; the sputum of tubercular patients whom he had subjected to this treatment was found to be very freely discharged with the acid. Some of his experiments are not only interesting, but certainly encouraging in their ascertained results. For example, he took two or three rabbits and injected into their lungs through a needle syringe a few drops of a solution of pure tubercular culture. In this way

he set up a local tuberculosis which became caseous but not generalised. Some of the animals soon succumbed to pulmonary tuberculosis, and the surviving ones were shortly after destroyed. Well-marked phthisis was found in all post mortems. He next repeated his inoculation on healthy rabbits in precisely the same manner, but he now fed the animals on bran mixed with boracic acid. After a time these also were sacrificed but, contrary to what he found in his initial experiments, their lungs were quite free from any tubercular lesion, neither was any found elsewhere. It is submitted that, although these experiments on rabbits may not be altogether conclusive as to a like action of boracic acid on human tubercular subjects, they are at least—in the face of the enormous mortality from phthisis and hopelessness of therapeutic methods in general in this disease—worthy of serious attention and more extended trial. As to clinical results, so far as it has been tried, the boracic acid treatment has been found to bring about a notable diminution in the expectoration, which became more fluid and less purulent. Considerable time is, of course, necessary before speaking of remote or final results, but in the cases in which the treatment has been tried, and which have been under observation for a considerable period, it may be said that in general that they improved in every way, while the tubercular trouble in the lung appeared to be at a standstill. The dose administered in these cases was one gramme in divided doses in the twenty-four hours. This, on the weight theory, must be considered insufficient. Taking the average weight of a patient to be sixty kilogrammes, and putting the limit of dose at twenty centigrammes for every three kilos, four grammes of the acid should be given per day, the dose being, of course, graduated up to this amount. Boracic acid will be found as a rule to agree well with the stomach, and is easily taken; it is not caustic, has no disagreeable taste, and in some cases was found even to check the diarrhoea when this existed.—*Lancet.*

Medical Items.

Dr. Robert B. Morison has returned home from the International Medical Congress.

The degree of LL. D. has been conferred on Dr. Robert Battey, of Rome, Ga., by the Jefferson Medical College.

Dr. A. W. Calhoun of Atlanta has received the degree of LL. D. from the University of Georgia.

The American Rhinological Association will meet at Louisville, Ky., October 6, 7, 8, 1890.

Dr. Neugebaur has been appointed Extraordinary Professor of Obstetrics and Gynæcology at Warsaw.

Professor C. Fürstner of Heidelberg has been invited to fill Professor Jolly's chair at Strassburg.

The State Board of Health accuses Lutherville of polluting Lake Roland. This may account for some cases of typhoid fever, dysentery, etc. in the city.

The library of the Medical and Surgical Faculty will be open from 12 to 3 P. M. only, until September 6th; after that date, from 12 to 7 P. M., as usual.

Dr. Benjamin Ward Richardson, F. R. S., has been elected President of the Association of Public Sanitary Inspectors in succession to the late Sir Edwin Chadwick, K. C. B.

It is reported that Mrs. Ayer, whose husband made some money in the patent medicine business, proposes to erect a three million dollar hospital for consumptives in New York.

The next Meeting of the Tri-State Medical Association of Alabama, Georgia and Tennessee will be held in Chatta-

nooga, Tuesday, October 14th, and will continue in session two or three days.

A moderate epidemic of typhoid fever has occurred at Princeton, N. J., which, if we are to believe press reports, has been traced, like the recent one at Waterbury, Conn., to a milk supply.

It is reported that the Court of Governors of the University College of South Wales and Monmouthshire have recently adopted a proposal to establish a department of medical science in connection with the institution under their charge.

The tenth annual meeting of the Ontario Medical Society was held at Toronto, Dr. J. A. Temple, of Toronto, president. About two hundred and fifty members were present. The president's address contained a strong plea for a uniform license in the Dominion.

According to the *Chemist and Drugist*, August 2, 1890, Mr. Thomas Beecham, manufacturer of the pills known by his name, makes nine million pills each working day, and spent last year over half a million dollars in advertising.

A preliminary meeting of the incorporators of the proposed Rush Hospital for consumptives in Philadelphia, has been held. The list includes many of the well-known names in Philadelphia medical circles. A location in west Philadelphia is under consideration.

Drs. Jacob Geiger, H. W. Loeb and J. W. Heddens having resigned from editorial duties on the St. Joseph *Medical Herald*, Dr. Daniel Morton has taken the helm, and will without doubt continue the successful policy that has marked the progress of our esteemed contemporary the last year or so.

The Jacksonian Prize for the year 1889 has been awarded to Mr. Walter

George Spencer, London, for his essay on "The Pathology, Diagnosis, and Treatment of Intra-Cranial Abscess and Tumor." The subject for the year 1891 is "The Pathology and Treatment of Diseases of the Knee-Joint."

A young woman in Summit county, Ohio, was supposed to be suffering from an ovarian tumor coming on, it was alleged, as a result of injuries sustained in a railroad accident. Her suit for damages was still pending against the railroad company when an operation was deemed imperative. The surgeon was somewhat surprised on opening the abdomen to discover a dead full-term foetus. The railroad company now disclaims all responsibility for the tumor. The wrong party was sued.

Dr. Pasternatski has found that a very convenient method for collecting and preserving for cultivation the spirillum of relapsing fever is to use leeches. If the leeches are kept in a cold place, the spirilla they contain preserve their vitality for a considerable period, much longer than they do when kept in capillary or other glass tubes. When exposed for some time to a temperature of from 27° C. to 30° C. the spirilla were found to undergo transformation into other forms.

The *Medical Record* says:—Ohio has over five thousand doctors. About one hundred were at the late meeting of its State Medical Society. Georgia has two thousand doctors. Eighty were at the last meeting of the State Medical Society. New York has probably ten thousand doctors. The attendance at the State Society meetings is never counted in more than the hundreds. Perhaps if the meetings were held only once in five years the attendance would increase. But then, perhaps, the length of the papers would too. Annual meetings with a slim attendance seem preferable.

MARYLAND MEDICAL JOURNAL.

VOL. XXIII. No. 19. BALTIMORE, SEPTEMBER 6, 1890.

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Original Articles.

FRACTURE OF THE PATELLA, AND ITS TREATMENT IN SAINT THOMAS' HOSPITAL, LONDON.

BY ARTHUR D. MANSFIELD, M. D.,
OF BALTIMORE.

It seems to me that the idea of the age is, that we always strive for new methods and cast away old and antiquated means as pernicious and of no use at all; this is wrong upon the very face, if it be carried out in all instances; but I can see a condition in which new methods are absolutely demanded. In all branches of our profession there are extremists, *e. g.*, a new remedy, say a drug, is introduced and immediately it is used for everything, but soon the uses become fewer and fewer until at last it may be

only indicated in one or two conditions, some other drugs find more or less use while others are never heard of any more. This spirit must of a necessity be in every growing and advancing science whether medicine, surgery, or any of the other sciences.

Again there are those which are so fanatical, yea, even antiquated, who degrade every new remedy as advanced and prefer to stay by those they find good; this is commendable but when carried to extremes it becomes, as I say, fanatical and antiquated. They are content with medium results in those things in which perfect results seem unattainable. Now I hardly need mention the fracture of patella as an instance in which we rarely obtain perfect results, hence it is that no two surgeons agree upon its method of treatment, or how to overcome the gradual and continuous traction of the quadriceps extensor muscle of the thigh upon the upper fragment of the sesamoid bone of the knee. This mechanical

principle has caused many devices to be put forward, and naturally I think the one I have observed as practised in St. Thomas' Hospital to be the best, else I would not offer it; for what is the use of advancing that which is of no practical utility? The fragments of the fractured patella can be brought in opposition, but how to keep them so? How to so relax the muscles as to prevent the tonicity of the muscles from gradually drawing upon them even when at rest? Extreme extension would naturally suggest itself as being the proper way, but practice always shows that only ligamentous union takes place and that as soon as any muscular activity is performed the fragments gradually separate. Bony union is the "ultimatum." Bony union is what we aim for. Can it be accomplished? Some think so and some others say nay. Well, we certainly should strive for a minimum quantity of ligamentous union.

Various have been the devices that have been advocated, such as clamps put on the bone, and by means of screws the two fragments are kept in opposition. Many objections can be advanced against this method, *imprimis*, it is cruel and causes the patient unnecessary pain; secondly it is a cumbersome apparatus; thirdly it has the further objection and that most general, the need of an apparatus, and most of the men in the medical profession are not engaged in hospital work, b it are in private practice. The instrument would not likely be in the possession of many; lastly it is complicated when compared with simpler means at our disposal, and we should always strive in surgery for the simplest means. Division of the tendon has been suggested, but tendinous union occurs very rapidly, hence the muscle gains all its former tonicity and again begins to draw upon the fragments.

As a *dernier resort* is the dangerous operation of opening the cavity of the knee joint and wiring the two fragments together. Much can be said in favor of this method, but one can easily see that the operation is grave and requires the strictest antiseptic precaution, and the

mortality of 1 per cent. makes it objectionable even when done under the best circumstances and under the best conditions. Most of these radical operations are done not at the time of fracture but after simple extension has been tried and non or imperfect union has resulted.

The method I have had the pleasure of witnessing in use at St. Thomas' Hospital, London, and as practised by Sir William MacCormac, the operating surgeon in charge, is as I will now detail to you.

The patient is a woman æt. 36, who had sustained a fracture of the left patella in the usual way, muscular violence, some two days before the patient was brought into the hospital. Sir William MacCormac speaks very enthusiastically of this method of treating fractures of the patella. The method in as few words as possible is to wire subcutaneously the two bones together or rather by a deep suture bind the two pieces together.

The patient being completely anaesthetized and brought into the operating theatre, the knee being thoroughly cleansed and washed with an antiseptic solution, &c., the operator passes a large curved and sharp point aneurism needle deep down into the knee joint about two inches below the lower fragment of the patella, the point of the aneurism needle emerges about an inch or so above the upper fragment of the patella and then it is threaded with a strong piece of silver wire and drawn back again, thus bringing the silver wire under the patella and out again having the two double ends of the wire, one below and the other above the knee-cap, and by pulling the two ends together the bones can be brought into opposition. This is done with little or no danger from septic infection if done in an aseptic way and accomplishes the same end as laying open the joint freely and wiring the fragments together and has the exceptional advantage of not exposing the patient to the dangers of exposing the synovial membrane of the knee-joint to any morbid germ that may find lodgment.

After the double silver wire has been

passed thus under the patella, the two ends are each grasped by artery forceps or pieces of wood, so as to form a means of holding the ends in a firm hold, the two ends are then brought over a pad placed between the two ends and over the knee, and twisted tightly together thus drawing the two fragments together and the pad serving the purpose of a protector to the skin from pressure that would necessarily be caused if the wires rested immediately upon the skin. The two ends being firmly twisted together, the whole is covered with cotton and bandaged closely and snugly and a plaster of Paris splint over the whole.

The main object and point is that this means at once simple and efficacious should be done at once upon the occurrence of the fracture and should not be done as a *dernier resort*, for of course then the results are not any better than any other method; the method must be adopted from the beginning, and then good results must surely follow. The plaster splint must remain on for 3 to 4 weeks and then its removed and the wires drawn out and the patient cautioned to be careful and not make any violent muscular movements yet awhile. Very good results are obtained I am told from this method, and perhaps it may find its advocate in this country of ours.

excessive secretion of the gland, second, by some obstruction to the free passage of the tears from the eye to the natural outlet under the inferior turbinate bone in the nose. The first condition is not very common. The second may be produced by misplacement of the puncta so that the tears do not readily find their way into the canal. This is frequently the result of ectropion or chronic conjunctivitis, or often from the absorption of the fat of the socket in old people, causing the eyeball to recede from the puncta, as it were. Sometimes one or the other punctum is closed, or there may be an obstruction in the shape of a partial or complete stricture of the canaliculus between the punctum and the sac.

In fact, the obstruction may be at any point between the punctum at one end and the orifice of the duct in the nose at the other, and it is of the very first importance for successful treatment that the exact seat of the trouble be located. And so again comes the necessity for a minute and careful examination of the individual case presented. In the cases where the punctum is closed or everted, or where there is a stricture of the canaliculus, a cure is readily made by the simple procedure of splitting up the canaliculus, but this should always be done in an upward and inward direction, especially inward. In cases where a solution of cocaine can enter the duct the operation is painless. In these cases there is no occasion for the passage of probes into the nasal duct.

Mucocele.—When the obstruction is below the sac the latter often becomes quite large and is filled with a collection of thick mucus, and the patient not only suffers from a watery eye, but has an unsightly lump in the corner by the nose, and is liable to frequent attacks of phlegmonous inflammation and abscess of the sac.

A mucocoele sometimes occurs, however, with the nasal duct quite open, and the collection of mucus can be pressed into the nose without difficulty. In either case, in order that the sac may be

THE DIAGNOSIS AND TREATMENT OF THE SIMPLER EYE DISEASES.

BY HERBERT HARLAN, A. M., M. D.,
OF BALTIMORE.

Assistant Surgeon Presbyterian Eye, Ear, and Throat
Charity Hospital, etc.

(Continued from page 376.)

Diseases of the Lachrymal Apparatus.—The most common symptom of trouble with the lachrymal apparatus is a watery eye, and this may be produced, first, by

treated properly, the canaliculus must be split as above, and in case of closure of the duct, that passage to the nose must be re-established. This having been done by the use of probes, the sac and whole lachrymal tract must be frequently thoroughly cleansed by antiseptic washes injected with a suitable syringe, and then some astringent should be used. For this purpose I have found nitrate of silver in the following prescription the best:

B Argent. nitrat. gr. v.
Aquaæ. ʒ i M

S.—Inject into the sac.

A word in regard to the use of probes. Those of Theobald having conical points are the best, and I believe the largest element of success in the treatment of these cases depends on the way in which the first probe is passed. Too small a probe should not be used. The very obstinate cases are chiefly to be attributed to injuries of the periosteum, and the forcing of false passages in the beginning of treatment. These cases even when dilated by large probes often close in a few weeks after the cessation of their use.

Neglected mucoceles frequently produce a *lachrymal abscess*, a painful affection accompanied by much redness and such an amount of swelling that the eye is often entirely closed. When seen early this abscess should be opened through the canaliculus. Later, this is not possible, and the incision must be through the skin of the cheek. When the abscesses are left to open of themselves, troublesome lachrymal fistulæ frequently result. After the escape of the pus and the subsidence of acute inflammation, the treatment is then to be directed to the dilatation of the lachrymal duct and the re-establishment of the natural channel for the escape of eye secretions.

Conjunctivitis; Ophthalmia.—The varieties of inflammation of the mucous membrane covering the eyeball and facing

the inner side of the eye lids, are grouped under the general term of ophthalmia or conjunctivitis, and for clinical purposes are divided into the following varieties:

Simple or hyperæmic.

Phlyctenular.

Catarrhal or muco-purulent.

Purulent (including gonorrhœal).

Granular.

Membranous (including diphtheritic).

In one or the other of these categories come the greater number of all eye diseases. All are troubles affecting the conjunctiva alone and a careful inspection of that membrane makes the diagnosis quite easy.

Conjunctivitis.—Under this head are all the so-called *colds* of the eye. It is not easy to be accurate about just what constitutes a cold in the eye, but we can be safe in saying that it is some acute inflammation of the conjunctiva. The facts are that changes of temperature alone have very little, if anything, to do with the causation of inflammations of the mucous membrane of the eye. The term "cold," however, is useful in satisfying the anxious patient with a name for his trouble.

In simple conjunctivitis the eye looks red; it is hyperæmic; there are sensations of something burning or itching. The conjunctival vessels are more or less engorged with blood, according to the severity of the case. And here it should be noted what vessels pertain to the conjunctiva and what to the sclerotic. The former are superficial, can be readily moved from one position to another over the eyeball on account of the loose connective tissue under them, and in a general way run parallel to the margin of the cornea, and can readily be emptied of their contents by slight pressure. The vessels of the sclerotic, on the other hand, are seen to be at a deeper level, are immovable, are most numerous at the corneal border, and run at right angles to the cornea.

The pink sclerotic zone is due to these vessels, and is very plain in cases where

the trouble is deeper than the conjunctiva, *viz.*, in the cornea, sclerotic, or iris. In conjunctivitis, there is most congestion on the eyelids, and it gradually lessens as you approach the cornea. In keratitis or iritis, on the other hand, the congestion is more deeply seated and greatest at the corneal border, lessening as you recede from it. Of course it must be borne in mind that there is some conjunctivitis accompanying all cases of iritis as keratitis. Among the most causes of simple hyperæmic conjunctivitis may be mentioned exposure to a glare of light, an atmosphere laden with particles of dust, some defect in the refraction, causing strain on use, irritation from foreign bodies, and not infrequently from a disordered digestion, a case of which may be mentioned in the red eyes accompanying a debauch.

For treatment, dark glasses, mild astringent lotions, and when needed the use of properly adjusted spectacles. As eye drops, the one I have found beneficial to the majority of cases is

R.—Powd. borax gr. xii.
Aq. Camphoræ

Aquæ $\frac{1}{2}$ ss

M. Sig.—A few drops in the eyes 3 or 4 times a day.

Where a more positive astringent is needed I use zinc sulphate or nitrate of silver gr. i to $\frac{1}{2}$ i.

(To be continued.)

DIFFERENTIAL DIAGNOSIS BETWEEN TYPHOID AND REMITTENT FEVER.*

BY CHARLES R. COLLINS, M. D.,
OF WASHINGTON, D. C.

There exists in the popular mind, and not without foundation, as I hope to indicate, the impression that medical men differ, not only more widely, but also more frequently in their opinions as to the character of the diseases they are called upon to treat, then those of other callings in life, about matters pertaining to their respective professions.

And it is with regret that there frequently occurs a conflict of opinions, when there is little or no ground for its existence. Especially so in my judgment is this case with reference to the two fevers that form the subject matter of this paper, because of the well marked phenomena that characterize each affection. It has come within my personal experience, and doubtless that of others, notwithstanding the line of demarcation that is so broadly between them, that errors in diagnosis are frequently made. In the outset I must say, I claim no originality whatever, for the description I am compelled to give of their origin, symptoms, progress in order as I have previously stated, to show that no embarrassment in forming a correct opinion ought to exist.

Familiar as you all are with these two maladies, the necessity for any minute, or elaborate description on my part is obviated. I will therefore briefly, yet comprehensively I trust, state their characteristics, so as to point out that they do not in any way or manner so closely approximate each other, as to mislead even the casual observer. The name "Typhoid" which has been generally adopted throughout the world, was first applied to this disease by Louis, whose clinical researches were of great value in all disease, but especially in this; that they es-

PRESCRIPTION FOR CARDIAC DROPSY.

Fürbringer uses the following in cases of dropsy from valvular insufficiency:

R. Infusion of digitalis 5ounces
Citrate of caffein 30 grains
Tinct. of strophanthus 75 minims
Solu. potassium acetate 15 drachms
Ext. of glycyrrhiza 75 grains.—M.

This amount is to be taken in two days.—*Medizinische chirurgische Rundschau*
August 1890.—*Medical News*.

*Read before the Clinico-Pathological Society Washington, D. C., December 3rd, 1889.

tablished beyond a peradventure the remarkable uniformity of this particular disease as it existed at different times and places.

It is a disease of antiquity, and one that has been much written upon as far back as medical literature extends. It is classed among the continued fevers, and marked by great prostration, disturbance of the nervous system, and constant anatomical lesions. Extremes of age are usually exempt, the disease selecting its victims from among those between the ages of eighteen and thirty-five. In this country it usually occurs in autumn, though it may occur at any season of the year. It is insidious in its inception, the patient for some days preceding an attack, feeling weak, distressed, listless, inanimate, and his countenance mirrors freely his deplorable condition. This is the dawn of the trouble, which is soon followed by the following symptoms: More or less chilliness, hot skin, frequent pulse, coated tongue, nausea, diarrhoea, epistaxis, headache, rose-colored spots, appearing upon the abdomen, chest or back. About the second week all these symptoms are more pronounced; the fever persists, the pulse is frequent and compressible, tympanites, gurgling in the right iliac fossa, nocturnal delirium, tongue dry and red, particularly at the sides and tip, sores on the gums and teeth, a slight cough, great restlessness, while the debility is extreme. The disease having now reached the third week, we may look for a change for the better or worse. Recovery may set in manifesting itself, by increased consciousness, and brightening of the countenance, or deadening insensibility, subsultus tendinum, frequent and feeble pulse, cold clammy sweats, indicate that dissolution is rapidly drawing near. The temperature of this fever in the morning of the first day may be stated at 98.5°, evening two degrees higher, and it continues to increase one degree every morning, the same difference of two degrees maintained between it and that of the evening, until it reaches 103° or 105°,

which is up to the end of the second week, the morning then being a degree lower. Thus much for this malady, as you are thoroughly conversant with it. Now it is necessary that I should present the distinguishing features of remittent fever, in order to show the lack of correspondence between the two diagnoses. This is preëminently a disease of warm climates, usually appearing in the spring and summer months.

Unlike typhoid its presence is not usually foreshadowed by any other symptom than that of gastric derangement, a sense of languor and lassitude. Instead of the treacherous beginning so characteristic of typhoid, we have a disease ushered in by a *marked chill*, immediately followed by a violent fever, temperature rising to 104° or 105°, pulse ranging from 100 to 120, face suffused, injected eyes, severe headache, pains in the limbs and loins, obstinate constipation, stools very dark (tar like) and offensive, the surface of the body appearing yellow, delirium occasional, and only when temperature is very high. In a variable period, usually from six to twenty-four hours, these symptoms decline, followed by slight sweating, the instability of the stomach lessens, the patient is composed, the temperature declines to 99 or 100, his head has ceased to ache, and he may pass into a comparatively refreshing sleep. Often some eight to ten hours, sometimes a shorter period, there is a recurrence of the symptoms, generally without the chill. This is the exacerbation which is again succeeded by the remission. Frequently the exacerbations are effaced and the fever assumes a continued type, or if not, the remission becomes more and more clearly defined, in fact more like intermissions, than remissions. The duration of this fever averages from 7 to 20 days unless protracted by complications. When the fever does not remit, but persists, symptoms similar to, if not identical with "typhoid" arise, to some extent giving it the combined character of the two affections, (typhoid and remittent), thus constituting the "typho-

malarial type." But notwithstanding this condition, we still have a sufficient predominance of the distinctive features of each affection, so as to avoid any mistake in diagnosis. Such a disease as "typho-malarial fever" as a morbid entity, or as the result of an individual poison, does not exist. While the term is a convenient one as expressing something less threatening than typhoid, and of more gravity than remittent, it has done much to confuse the mind of the practitioner and consequently increase the suffering of the unfortunate patient.

Now then, I have hastily, yet trust faithfully, given the symptoms of these two disorders, it becomes me to point out the dividing line between them.

You have no well defined periodicity in typhoid fever, but as characteristic, you have diarrhoea, deafness, eruption, thoracic and abdominal symptoms. Sometimes the two affections seem mixed, to wit, typhoid fever appearing in a malarious section, there are often distinct exacerbations and remissions obscuring the real ailment.

As is said by eminent writers, the malarial influence has set its mark on the disease, and some days completely masked it, but this is of short duration. The great prostration, the low delirium, the thin passages, so unlike the dark hard stools of remittent fever, the tympanitic abdomen, the epistaxis, the decubitus of the patient, who constantly slides from the pillow to the centre of the bed, the character of the tongue, the temperature as it appears during the progress of the affection, the eruption as it is manifested, the duration of the two, all indicate the difference between the two ailments. Even should there exist an absence of any one or more of these features, there still remains a sufficient number upon which to predicate an opinion.

Should there be manifested periodicity in typhoid, which I admit is occasionally, but rarely, shown, you then have the prior history of the case to militate against any false conclusion. Where remittent passes into continued, it is

marked by muscular prostration, subsultus tendinum, picking at the bed clothes, dark dry tongue, feeble pulse, and, it may be, diarrhoea. It is this form of fever which has been mistakenly pronounced typhoid, but there is still absent the lesions of the true typhoid; in a word, it is a typhoid state.

I can readily comprehend why conflict of opinion among medical men should occur in disorders whose symptoms are obscure. In some forms of mental alienation where expert testimony is introduced, both in civil and criminal cases, more especially the latter, the discrepancy arises from limited experience, *generally*, of such cases or lack of knowledge of the previous history of the particular case under judicial investigation. In these cases the want of agreement is excusable because of the embarrassments that are peculiar to such afflictions. My object in the selection of this subject, that I now bring to a close, regretting my inability to do full justice to it, is simply to direct attention to the importance of a careful observance of the phenomena of these two diseases, so as to lessen the amount of contrariety of opinion, which tends not only to injure the practitioner who is in attendance upon one or the other of these cases, but also to lessen the faith of the laity in our profession.

Society Reports.

MEDICAL AND SURGICAL SOCIETY OF BALTIMORE.

STATED MEETING HELD APRIL 10TH, 1890.

The 709th regular meeting of the Society was called to order with the President, Dr. H. T. Reynolds in the chair.

Dr. Hiram Woods read a paper on
GRANULAR SUPPURATION OF THE
MIDDLE EAR,
(See page 215, Vol. XXIII),

and exhibited a specimen of a polypus.

Dr. Wm. H. Norris asked if the pure chromic acid or an aqueous solution were used on the granulating surfaces; and would also ask what remedies were used for chronic eczema.

Dr. J. W. Chambers said the specimen was a multiple papilloma and not a true polypus. He had one, identical with this, that weighs about two ounces, which he had removed from the rectum of a patient. There was a thin mucoid discharge from the rectum, with an offensive odor, but it was not true pus.

Dr. Woods said, in answer to Dr. Norris, that eczema is dependent on other causes and we waste time in treating the eczema and neglecting the primary cause. An eczema may be cured by the acrid discharge of an otorrhœa, and until the otorrhœa is cured, the eczema will not be. He had a patient, a lady who has an eczema, caused by a chronic otorrhœa with a contracted and crooked canal and as thorough cleanliness is almost impossible, making the treatment of the otorrhœa more or less ineffectual, the eczema is there.

In poorly nourished children, good food and tonics are indicated, though these cases are not often seen in private practice. They are seen most often in dispensary practice. The officinal ointment of zinc oxide or yellow oxide of mercury, two grs. to the drachm of vaseline, are good applications. In the dry scaly eczema of the ears, he sometimes finds the ointment of six minims of the oil of cade to the drachm of vaseline to give good results. Roosa objects to the salves on account of their producing temporary deafness, and recommends a strong solution of nitrate of silver, about xl to lx grs., to the ounce. As to the use of chromic acid to granular surfaces of the ear, he uses it pure, that is, he moistens a bit of cotton on an applicator and dips it in the chromic acid, a crystal or two will adhere to the cotton and it is then applied.

Dr. J. W. Chambers then exhibited a patient with a

THORACIC ANEURISM.

Colored man, aet. 31, driver, has been about the city hospital for a number of years. He would be given some simple remedy now and then by one doctor, then another, for some undefined ache or pain here and there, but had not been under any systematic observation or treatment. About three years ago he began to suffer in the sterno-clavicular region. In September, 1888, this had become a fixed, severe pain. Dr. Chambers examined his heart and found a regurgitant, aortic murmur; he gave him digitalis and the patient improved for awhile. Three months later a more careful examination was made and a marked pulsating tumor was found in the sterno-clavicular region, and that articulation moved with each impulse of the heart. The characteristic aneurismal "bruit" and other symptoms were present. He could only sleep when under the influence of morphia. During his invalidism he would have spasmodic attacks of coughing, and Dr. Chambers expected the patient would die in one of these attacks. At one time he could not bear the slightest touch over the clavicle, which was attributed to periostitis. At one time ligation of the innominate and subclavian and carotid arteries was thought of, and, in fact, he asked to have it done. In this case there is no definite cause. All traumatism can be excluded. There is no syphilitic history; certainly not in the last ten years, during which time he has been known by Dr. Chambers. It may be due to disease of the arterial walls with dilatation, or it may be secondary to embolism. He is an active, quick man, and has some athletic ambition, and it may be due to disease of the arteries from this cause of constant strain.

An aneurism may be cured in more ways than one. By Broca's active clot, by lamination, and one end may become clogged up and nature effect a cure in this way. Nature gives us the indications for treatment. Anything that will

slow the blood current and cause coagulation is proper treatment. Arterial sedatives, ligatures, iodide of potash and saline cathartics and complete rest. This patient was given iodide of potash in large doses and was kept in bed on his back for months. At first he was intolerant of iodide of potash and begged to have it stopped. He was kept on it however and took from 60 to 180 grains in 24 hours. He is not cured, but his condition is very much improved, so that now he attends to his work and is able to make his living. The tumor is still present, but is much reduced in size, his appetite is good and he sleeps well, he has no cough, dyspnœa, or difficulty of deglutition as he had, and has gained in flesh from 114 lbs. in last July to 134 at present.

The lesson to be drawn from this case is not to give a patient up with aneurism no matter how bad he may be. Those of us who give iodide of potash, meet cases now and then who cannot take it. They come back to us with an intense coryza and complain bitterly, but if the drug is persistently taken, they establish a toleration for it, and all these symptoms pass off. Dr. (Dr. Chambers) had a patient with cerebral syphilis, his pupils were unequal, one widely dilated, the other contracted. The patient was an expert penman, and was so bad that he could not write his name. He came back after taking grs. v doses of iodide of potash for several days, with symptoms as described above. He was told to persist in the use of the medicine, and it was increased until he took grs. lx, which he took for one month, and he was then able to resume his occupation.

Dr. Woods said he recalled a case similar to the one related by Dr. Chambers. The patient was in the wards of the hospital of the University of Maryland, when the speaker was a student. He had a large pulsating tumor in the lower part of the neck, which was diagnosed to be an innominate aneurism. The patient came from Philadelphia, where he had been offered the operation

of ligature and had refused it. The treatment employed was rest in bed, the application of a rubber strap over over the aneurism and the administration of the iodide of potash. The dose was run up to grs. lv, three times a day, and after prolonged treatment the swelling was pretty well diminished and the patient's comfort increased. He agreed with Dr. Chambers as to the transient character of the symptoms commonly called iodism. He had a case last winter of total paralysis of the motor-oculi, occurring in a patient with tertiary syphilis. Iodide of potash was given, commencing with grs. v, three times daily, and speedily increased. Iodism was manifested when the patient was taking grs. xv doses. The drug was continued in spite of these symptoms, which gradually passed off and the dose gradually increased to grains xxx. The ptosis now commenced to disappear, but it required grs. xlvi three times daily before the ocular muscles regained their power. With the exception of the acne and the conjunctivitis there was no return of the disagreeable symptoms. He thought it was a mistake to suppose that because a patient improved when taking iodide of potash that the disease was syphilitic. This opinion has been advanced more than once in this city. The drug seems to promote absorption, whether the growth to be removed be syphilitic or not.

Dr. Geo. H. Rohé said Dr. Ward, of North Carolina, had a case of aneurism which he treated with large doses of iodide of potash and rest. The patient considers himself cured in that he is enabled to perform his accustomed work. About six years ago he had a case of a colored woman, who had a pulsating tumor in the abdomen. Dr. Jos. Branhams saw it and agreed with him that it was an abdominal aneurism. She was put on large doses of iodide of potash and rest. She was examined about a year afterward and the tumor was still there, it had lost its dilating character. A year after she was examined and the bruit had

disappeared. He agreed with Dr. Woods in that all troubles are benefited by iodide of potash, are not for that reason symptomatic.

J. WM. FUNCK, M. D.,
Recording and Reporting Secretary,
1710 West Fayette street.

FATAL POISONING WITH SALOL.

Dr. Hesselbach reports, in the *Fortschrifte der Medicin*, the case of a young man suffering with rheumatism, who took by mistake two drachms of salol. Coma resulted, with great dryness of the tongue, anuria, and death on the second day. At the necropsy, the kidneys were found to be soft, anaemic, and of a pale-yellow color; microscopically, the glomeruli were full of embryonic cells and leucocytes, the convoluted tubes were tumefied, and fatty degeneration had begun. The tubuli were filled with degenerated epithelium. There were no other lesions attributable to the drug. The toxic principle was the carbolic acid that is generated from salol in the system; and the author believes that it should be prescribed carefully, and the condition of the kidneys, as indicated by the urine, carefully watched.—*New York Medical Journal*.

TREATMENT OF PULMONARY TUBERCULOSIS.

The late Dr. Brehmer, who treated cases of phthisis so successfully in his sanitarium at Goebersdorf, was a strong advocate of the treatment of the disease in sanitaria. Such institutions, he believed, should be situated among the mountains, as the elevation increases the heart's action through diminished atmospheric pressure, and improves nutrition by stimulating the appetite. The locality should be immune from phthisis, and well sheltered from winds, which are especially injurious. Patients may be allowed considerable exercise in the open air, but upon the least fatigue rest is exceedingly important. Dr. Brehmer, believing nutrition to be of great importance, provided his patients with five meals daily, vegetables occupying a prominent place in the dietary. Every patient should

also take three pints of milk daily, increasing to four pints if anorexia is pronounced. Wine is useful because it increases the power of the heart and economizes nutrition.

In the symptomatic treatment, dry, irritative cough should be controlled by "physical influences," and by drinking of cold water or of hot milk with seltzer. Morphine is indicated only when the cough is accompanied with expectoration and interferes with sleep. Moderate haemoptysis checked by the hypodermic injection of morphine, and an ice-bag to the cardiac region. Ergotin may be used if necessary. In profuse haemoptysis violent coughing is often necessary to dislodge the clots, but if insufficient they may be removed by a finger introduced into the larynx. If there is much weakness and dyspnoea champagne is a useful stimulant. Fever may be reduced by cold to the praecordium, but if this is not effectual antipyrine or antifebrin may be employed. Night-sweats can often be prevented by the ingestion of a glass of milk containing one or two teaspoonfuls of cognac.—*Occidental Medical Times*, August 1890.—*Medical News*.

THE MORTALITY OF WIDOWERS FROM PHTHISIS.

In a paper on Tuberculosis in Belgium MM. Destrée and Gallmaerts come to the conclusion as the result of their investigations that, in comparing the mortality from phthisis of bachelors, married men, and widowers, the last are very much more subject to this disease than either of the other classes. The same statement holds good for all ages, and it is, they say, also true that widows are more liable than single women to die of phthisis. The authors do not think this is to be explained except by direct contagion of wife to husband or husband to wife. They cannot think irregularities and excesses indulged in by widowers can be answerable for it, for advanced age does not seem to make any difference. They would ascribe it to infection occurring during married life, the disease claiming its second victim some time after the death of the first.—*Lancet*.

MARYLAND MEDICAL JOURNAL

Weekly Journal of Medicine and Surgery,

WILLIAM B. CANFIELD, A.M., M.D., Editor

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BALTIMORE, SEPTEMBER 6, 1890.

Editorial.IS "RUXTON" A MENACE TO THE
HEALTH OF BALTIMORE?

No citizen who takes an interest in sanitary matters can view without apprehension the multiplication of cottages at the head of Lake Roland. From this little lake, a few miles out on the Northern Central Rail-Road, a large portion of the city receives its water supply. Complaints have already been made because a portion of the Towson region drains into one arm of the lake, and as the Towson neighborhood is frequently visited by little epidemics of dysentery and typhoid, wonder has been expressed that no intercepting sewer was

used to divert this drainage from the lake. It is, however, to another arm of the lake, running northward, that attention is now asked. In the low valley which surrounds this head of the lake the settlement called "Ruxton" is being formed by certain landowners living in Baltimore. Already about a dozen cottages have been built there. Now these cottages must have privies and perhaps stables, and privies and stables imply pollution of the lakes and streams above which they are situated. There has been typhoid fever in this region, not in the valley but in the hills about it, this summer and there is no reason why it should not visit Ruxton. The matter should receive attention from our Board of Health, as the settlement is growing rapidly. There are many cities which delight in the use of river water tinctured with sewage, but the idea is very repulsive to a Baltimorean.

SOME OF THE RELATIONS OF
CLIMATE TO HEALTH AND
DISEASE.

Dr. W. Everett Smith (*Boston Medical and Surgical Journal*, August 21st, 1890), in discussing the relation of climate to health and disease draws the following conclusions:—

(1) In tracing a connection between the weather and disease, the tendency is to go too far and ascribe to atmospheric conditions more of an influence than we can prove. Because a climate may expedite or inaugurate a cure is no inherent proof that a climate, even though it have the opposite atmospheric conditions, will, *per se*, cause the disease.

(2) Climate means more than the weather, and includes data concerning

the contour of the land, the situation of hills and forests, and the nature and chemistry of the soil.

(3) With no reason can we measure a climate by its absolute humidity alone, or ascribe to absolute humidity the supreme control over the origin of disease. Coincidence of data does not necessarily show a causative relation.

(4) The degree of absolute humidity is more a resultant than a cause of atmospheric conditions, although it may be frequently a *mediate* cause of atmospheric changes. In no way, however, can we measure the value of absolute humidity or discuss its influence upon our bodies until we bring it in relation with something beyond itself. We are, therefore, constantly discussing *relative* humidity, —if we use the English language with its proper meaning.

(5) To assume that the weather controls health and causes disease by its influence upon the respiratory organs alone, is to utterly ignore the vascular and secretory systems of the body with their important functions. The assumption being unwarrantable, all conclusions and inferences based upon it are illusory.

(6) *Absolute* humidity, *per se*, can have no influence upon health. Its influence depends upon the temperature and accompanying atmospheric conditions. A low *absolute* humidity in cold air is the mediate factor in abstracting *heat*, not moisture, from our bodies. A low *absolute* humidity in hot air will abstract moisture from our bodies proportionate in amount to the degree of *relative* humidity in which our bodies live.

(7) *Relative* humidity measures the moisture-absorbing powers of the air, is an expression of our surrounding atmos-

pheric relations, and is modified by and gives us a working notion of the direction of the winds and, at times, of the amount of sunshine. It represents conditions that are necessary to health and essentially local in their nature. It is, therefore, of great value to the physician.

(8) The best single datum to be used with the temperature is the *dew point*, since in combination with the temperature it will enable us to determine both the *absolute* and the *relative* humidity. Definitely given also the amount of sunshine or of cloud, we can form a fair idea of the hygienic value of a given locality to health.

(9) Condensed moisture has a great influence upon health. In some of its phases, it is equally as important as humidity (aqueous vapor). When in the form of mists, exhalations and fogs it has, unfortunately, often been confounded with humidity.

(10) The chief atmospheric conditions modifying health, and therefore causing disease, are sudden and violent *daily ranges in temperature* and secondarily *in relative humidity*.

(11) The *barometer* is an important but too frequently neglected instrument. A single observation of it gives us nothing that is of true value until it has been compared with preceding and succeeding inspections. The barometer should be in a physician's office for daily use and not for mere display.

(12) We know, beyond doubt, the influence which certain low and wet localities exert upon health, but we do not understand completely the Why of this influence, so that we are not yet able to formulate with precision the general law under which our empirical observation is a particular instance.

(13) I venture the prediction that when in future years our knowledge of the electricity of the atmosphere is more completely studied we shall find in that mysterious force some solution of this problem. But I spin no gauzy theories upon the subject.

Correspondence.

MUNICH LETTER.

ANNIVERSARY OF THE FALL OF THE BASTILE—A NATIONAL FETE AT ZURICH—MUNICH AND ITS UNEQUALLED BEER—THE LÖWENBRAUHAUS AND HOFBRAUHAUS—THE DEAD-HOUSES—PRECAUTION AGAINST BURIAL ALIVE—THE PASSION PLAY AT OBERAMMERGAU; ITS SOLEMNITY.

MUNICH, July 25th, 1890.

Editor Maryland Medical Journal:

DEAR SIR:—I wrote you last from Paris, where Dr. Chisolm and I spent a charming and profitable week. We were there on the day of the National Fête, (14th of July), commemorative of the fall of the Bastile. It was the most remarkable celebration I have ever seen. The review of troops—about thirty thousand—in the Bois de Bologne—with the addition of about forty thousand spectators—the illumination of Paris—the fire works—the dancing and hilarity in the streets—all showed Paris in a blaze of excitement that could only be produced by Frenchmen. Every few squares throughout the city, there was music and dancing in the streets, where I witnessed from three to five hundred couples on the whirl at one time. This was interspersed with hugging and kissing, which were freely given, and as freely taken. I shall never forgive my “cabby” for breaking up a poor fellow, in the midst of the Avenue de l’Opera, engaged in this tender recreation, by calling to him to “stop that.” The “cabby” got a full round

shower of oaths upon him, for the interruption. The dancing commenced at 12 o’clock on Sunday (13th), and continued all that day and night. It commenced again at 12 o’clock on Monday (14th), and continued throughout the day and night, with every variety of step, and every conceivable costume. I shall never forget this fêté day in Paris.

We left here soon after for Zurich, via Bâsle, passing through a flat and uninteresting country, until we struck the Swiss border. It was a fourteen hour ride, and a very hot day. We were ready for a good dinner and bottle of wine (2fr., 50cts., each), which we got in Bâsle at 6 P. M.

Zurich is a beautiful city situated on the lovely lake of the same name. It is celebrated for its immense silk manufacturers, and the cheapness and advantages education. I spent several days there, and was fortunate in being there on Switzerland’s National Fête day. The fire works and illumination of the Lake with Chinese lanterns, and all sorts of lights, on innumerable boats, moving from place to place, presented a fairy scene, rarely beheld and not easily described.

Mr. Otto Sutro and family, of Baltimore, were with us here.

The ride to Munich was eight hours, giving us an hour and a half on Lake Constance, in a beautiful little steamer, where we had a good dinner on the upper deck, and a good bottle of wine, for 3 marks (75 cents), each.

The chief end of man, in Munich, seems to be to drink beer, and the chief end of woman, to work. I never saw so much beer drinking before. It is acknowledged to be the best in the world, and it must be so, from the quantities of which they dispose.

They drank from stone mugs, with metal tops, holding over a quart. These are called “krugs”; the pint mugs are called “schnitts.” The latter are very rarely called for, for nothing less than a krug is worthy of the notice of a loyal German,

and I felt humiliated that I was hardly equal to a schnitt. Still, I did my best, and my friend, Dr. Chisolm, told me I was improving so rapidly there were hopes of me. He had already attained the stature of a full-grown man.

We went one evening to the celebrated beer-garden called "Löwenbräu;" fifty pfennigs (12½ cents), admission; a grand band of music; capacity for 6,000 people. Scarcely a vacant seat to be had; everybody—men, women and children—drinking beer; all talking, none listening. It was truly to me a "confusion of tongues."

The next evening we went to the Hofbräu. This is an immense hall where the lower classes go to drink beer, which they get at a nominal price. The Hofbräu, or Royal Brewery, is under the care of the Government, and is said to produce the finest beer in Munich. In this way the authorities see that the masses get a pure article. Here every man washes his own quart mug, and goes to the drawers to have it filled. Every seat in the place was filled, and wherever there was standing room. We worked our way through the crowd, and took a rapid view of the place, too glad to escape to the open air, away from the fumes of beer—for there was beer in casks, beer on the floor, beer on the tables, beer in mugs, beer in the air, and beer in stomachs.

The people of Munich are very apprehensive of being buried alive, and there is a law which compels every dead person, high and low, rich and poor, to be removed from the place of death within six hours after dissolution. They are taken to the dead-houses, which are located in the cemeteries, their head and shoulders propped up in their coffins, in a reclining position, an iron ring put on the right forefinger, which is attached to a wire, which leads to clockwork in the room above, where the keeper sleeps, so that if at any time life should return to the corpse, the finger would move and a bell would be rung in the upper room, where

some one is always on watch. In this position, in rows on tables, the bodies are required to be kept not less than forty-eight hours or more than seventy-two hours, when the funeral ceremonies take place and they are buried.

There are seven cemeteries in Munich, and every one has such a dead-house connected with it. I visited one of the most fashionable, viewed the dead bodies, and had a long talk with the keeper. I saw seven corpses of grown persons in one room, in a semi-sitting position in their coffins, and five infants in another room in the same position.

They were surrounded by a profusion of most beautiful flowers, literally sleeping in beds of roses, with flowers artistically arranged in bowers above them. The perfume from these flowers gave the rooms a delicious odor.

The keeper told me he had been in his position twenty years, and his father had been in the same position thirty years, and in all that time there had not been a single instance of returning life in a corpse; and moreover, that there had not been such an occurrence in all the dead houses of Munich in this time—strong testimony to prove that people are never buried alive, unless possibly in very deadly epidemics.

A first-class funeral, including the dead-house charges and flowers, costs 1,200 marks, or \$300.

From Munich we went to Oberammergau to see the Passion Play. This was by far the most wonderful performance I have ever seen. I was most agreeably disappointed. Nothing could have been more solemn and impressive. Nothing could have been more realistic of Christ's death and sufferings, of the scenes through which He passed, and of the persons who aided, abetted and consummated His crucifixion; and no one could see it without feeling a deeper love for Christ, and a higher appreciation of what He suffered for them.

It was the most solemn audience I ever beheld—more so than the service of any

church I have ever entered. For eight and a half hours, five thousand people sat witnessing this play. There was no restlessness, no whispering, no looking about, no nodding, no *applause*. Every one deeply intent and solemn, and tears streaming down the cheeks of many. The theatre was only partially covered, so that one-third of the audience sat the whole day in a pouring rain, with nothing but the Heavens above them, and without a murmur. They must have been wet to their skins; they were not allowed to hold up umbrellas.

These circumstances, when taken in connection with the fact, that the play is rendered by the inhabitants of this obscure village (without the aid of a single professional) all of whom are more or less manual laborers,—makes the wonder greater, in witnessing this play. Joseph Mayer, who takes the part of Christ, is a wood-carver, and not a single actor has a higher position in life. Seven hundred persons took part in the play. Nobility, and the humblest peasants, alike, composed the audience. The price of seats was from one to ten marks. (25cts. to \$2.50). We were fortunate in securing the best seats at the latter price.

If I can find the time I will let you hear from me at Birmingham, where I expect to attend the meeting of the British Medical Association, and be the guest of Dr. Thomas Savage,—surgeon to the Sparkhill Hospital for women.

Faithfully yours,
H. P. C. WILSON.

Reviews, Books and Pamphlets.

Description of the Johns Hopkins Hospital.

By JOHN S. BILLINGS, M. D., Baltimore, 1890.

This “*édition de luxe*,” or “*Pracht ausgabe*,” has been prepared by Dr. Billings by order of the Board of Trustees of the Johns Hopkins Hospital. It contains letters of Dr. Billings and Mr.

Hopkins, the addresses delivered at the opening of the hospital in 1889 and a very full description of the grounds and buildings. The book has been very carefully prepared and is an exceedingly valuable addition to the literature of hospital construction.

As the description of the hospital has probably been in manuscript for some time, it is simply an exposition of the plans of the designer and not a report of the workings of these plans. It is well known that while the systems of heating and ventilating were most carefully studied and planned from every scientific standpoint, it was not known what the practical outcome of these plans would be until they had been in use at least during the four seasons. Again, the conveying of the food from the kitchen to the most distant wards was so planned that the food should not lose heat. Unfortunately, this is not so, as experience has shown, and it is even suggested that the elaborate heating and ventilating system, while equal to that of most hospitals, does not come up to the original extensive plans. A report of the hospital plans written a few years hence with the original plans and the changes which experience will show to be necessary, would be a very instructive work.

As it is, the hospital is as near perfect as human means can render, and the watchful eye of trustees, managers and staff will soon make known the defects.

The typography of the work reflects great credit on the Publication Agency of the Johns Hopkins University and the press which did the work. The photogravures of Gutekunst and the block plans are most elaborately distributed throughout the text.

Cœliotomy: This, and not Laparotomy, is the Proper Greek Synonym of Abdominal Section, Laparotomy being an Incision of the Flank only. By Robert P. HARRIS, A. M., M. D., Philadelphia, Fellow of the College of Physicians, etc. Printed for the author by William J. Dornan, Philadelphia. 1890.

Scheme of the Antiseptic Method of Wouud Treatment. By DR. ALBERT HOFFA. Privat Docent of Surgery in the University of Würzburg. Translated from the German, with Additions, by special Permission of the Author, by Aug. Schachner, M. D., Ph. G., Louisville, Ky.

Miscellany.

PAROXYSMAL PULMONARY CÖDEMA IN CHRONIC ALBUMINURIA.

Pulmonary cödema in cases of chronic renal disease is an important factor, and Professor Bouveret, of Lyons (*Revue de Méd.*, pp. 241-251, 1890, and *Practitioner*, August, 1890), is anxious to call attention to a paroxysmal form which seems to him, though rare, not to have received sufficient attention. The characteristic symptoms are a rapid onset of dyspnœa, with a very abundant albuminous expectoration. Such attacks recur rapidly, ending either in death or in sudden and complete relief. Dr. Bouveret has met with only two cases; both of them in patients with chronic interstitial nephritis. In the first, a man, aged sixty-two, who had long-standing granular kidney, the dyspnœa was very severe, though irregular, before death. The tension of the radial pulse throughout. The sputa amounted to about three pints *per diem* of a frothy and highly albuminous liquid with occasionally a trace of blood in it. Patient was bled and cupped, and treated with strong hydragogue purgatives, but died in asphyxia, at a temperature of 104.2°. The necropsy showed much destruction of the cortical tissue of the kidneys of old standing, extreme cardiac hypertrophy and dilatation, and a remarkable abundant cödema of the lungs, with no broncho-pneumonia. In the second case, a man, aged forty-five, there were in two years three crises of dyspnœa, and abundant albuminous expectoration, followed in each instance by

a rally. In the last and most violent crises, which came on very suddenly, and without apparent reason, when he was going to bed, and lasted only four hours, he coughed up about three pints of fluid. The day after the attack he felt strong enough to get up and do some work. He was probably in an early stage of contracting interstitial nephritis. At the times of dyspnœa and abundant expectoration very little urine, and that of high specific gravity, was passed; at the other times it was abundant and of low specific gravity. His heart was not much hypertrophied, and its valves were efficient. Fräntzel, in discussing similar symptoms, is inclined to attribute them to a loss of equilibrium of energy between the right and left ventricles; the left ventricle in fact giving way suddenly under its constant heavy work. That is a view supported by Dr. Welch, but quite inconsistent with the high arterial tension in the first case mentioned, and with the normal tension and very slight cardiac hypertrophy in the second case. Professor Bouveret is inclined to suspect a vaso-motor paralysis of the pulmonary arterioles, though he admits he cannot point to the nervous origin of this vaso-motor paralysis. He advocates a treatment by bleeding, dry cupping, poulticing the thorax, and administration of hydragogue purgatives and alcohol in large doses, in extreme cases of cardiac failure, subcutaneous injection of caffeine and ether. In the first case such treatment was adopted without success.—*Boston Medical and Surgical Journal.*

ACUTE YELLOW ATROPHY OF THE LIVER.

Dr. Rosenheim reports a case of acute yellow atrophy of the liver in a child of ten in which crystals of bilirubin were found in the urinary deposit. These crystals have never, as far as Dr. Rosenheim is aware, been found before, except in the urinary tubules in *icterus neonatorum*. There was no albumen in the urine, only traces of propeptone and no

peptone. Evidence was found of a considerable amount of degeneration change in the kidney parenchyma by the existence in the urine of granular casts. Epithelial remains and globules of fat were also found. As regards the etiology of the disease, Dr. Rosenheim is not inclined to share in the view of Klebs and Eppinger, by whom acute yellow atrophy is looked upon as an infectious disease produced by special microbes, because he was unable to detect any micro-organisms in sections of the liver, and his endeavors to obtain cultures failed. He is much more disposed to ascribe importance to the finding of masses of bacteria in the blood circulation, in consequence of which pathological changes in the liver may be set up. He is himself inclined to think that bacteria whose habitat is unknown produce some chemical body which exerts a deleterious effect on the parenchyma of the liver, and produces the characteristic morbid changes of acute yellow atrophy.—*Lancet*.

BAD BREATH.

Dr. Frank H. Gardner, in the *Dental Review*, speaks of the causes of bad breath. He concludes. First, decaying particles in the mouth as far back as the pharynx vault taint the breath, if exhaled, very little if at all. Second, mouth-breathers have a bad breath when the tonsils are enlarged, or when cheesy masses exist in the tonsillary mucous folds. Third, certain gastric derangements taint the breath only when gases are eructated through the mouth. Fourth, the principal cause of bad breath is decomposition in the intestinal canal, the retention of fecal matter in the transverse and descending colon, and the absorption of gases into the circulation, finally exhaled by the lungs. Fifth, catarrh, nasal, pharyngeal or bronchial causes bad breath. Sixth, medicines or ailments which undergo chemical changes below the oesophagus may, by rapid absorption through the stomach walls, or immediately below, give to the

breath the characteristic odor. Bad breath is often a source of serious annoyance to the patients, and the fact that it has more than a local cause is too often ignored by the physician, who therefore fails to cure it.—*Buffalo Medical and Surgical Journal*.

ANTISEPTIC VAGINAL INJECTION.

R.—Bichloride of mercury	4 grains.
Sulphate of copper	15 "
Chloride of sodium	15 "
Tartaric acid	8 "
Indigo	a trace.
Distilled water	2½ drachms
Glycerin	2½ "

—M.

This is to be added to one quart of water, and used after labor, if an injection is required.—*Gazette de Gynécologie*, August 1, 1890.—*Med. News*.

PLUMBISM AND ALCOHOLISM.

At a recent meeting of the Academy of Sciences, M. Charcot, read a note on some experiments in plumbism carried out by MM. Combermate and François. They caused from one to five centigrammes of carbonate of lead to be consumed daily by animals. At the end of about a month the nervous symptoms of saturnine poisoning made their appearance—such as epileptic fits, delirium, etc.—just as they are observed in man. This was, of course, not new; but the interesting point was that in certain of the animals experimented upon the administration of large doses of alcohol was found to hasten in a remarkable manner the advent of the nervous symptoms. The same thing was noticed when others of the animals were subjected to any abrupt emotional shock, such as fear. These facts were worthy of note, for in man a similar precocity of the nervous phenomena of plumbism was observed whenever those already suffering from lead poisoning were subjected to a moral shock or became addicted to alcohol.—*Lancet*.

THE INFLUENCE OF DRUGS ON ABSORPTION.

The importance of a knowledge of the process of absorption taking place in the intestine cannot be over-rated, and consequently any addition to our information on this subject is to be welcomed. The absorption of drugs by the intestine has been very little investigated, and it is on this point that Leubuscher of Jena has made some experiments. The process of absorption must no longer be considered a purely physical one, but a function of living cells, so that any causes which may injuriously affect the life of these cells will also interfere with proper absorption. The cells may be altered by influences acting directly on themselves, or through the blood current, or through means of the nervous system. With regard to direct injury of the cells, Leubuscher experimented by isolating a small coil of intestine in a living animal by means of light ligatures, and then injecting a strong solution of a mineral acid, washing this out with water and introducing a known quantity of grape sugar in solution. Compared with a normal intestine, the quantity of grape sugar absorbed was considerably lessened. In other experiments, the artery supplying the coil was tied, or the vein leaving it, producing in the one instance anaemia and in the other congestion; in both cases, but more especially in the latter, absorption was greatly interfered with. Investigations as regards the third division—namely, the effect of the nervous system—could not be fully carried out. The action of various drugs was then tried. Grape sugar and a solution of iodine in iodide of potassium were used as tests of the power of absorption, and the following drugs were selected: quinine, opium, alcohol, glycerine; also weak solutions of common salt and Carlsbad waters. Coils of intestine were exposed and isolated in two animals. In one the grape sugar or iodine solution alone was injected, and in the other the same mixed with the drug to be tested.

The results were afterwards corroborated in animals in whom an artificial intestinal fistula had been secured. Quinine, opium, and morphia, even in weak solutions, interfered greatly with absorption. Morphia acted in the same manner when it was introduced into the system by means of hypodermic injections. Alcohol in weak solutions (3 to 2 per cent) increased absorption, but in large quantities hindered the process. Glycerine produced no decided effect, weak solutions of common salt increased, and Carlsbad water had no effect, on absorption. A few experiments were also tried by estimating the quantity of iodide of potassium passed within a certain time in the urine of patients after a dose of this drug had been administered by the mouth, the iodide being dissolved either in water, alcohol, glycerine, Carlsbad water, or milk. With alcoholic solutions the quantity was increased as compared with the watery solutions; with glycerine, this was the same as with water; Carlsbad water also increased it, but milk lessened the quantity —*Lancet*.

INNERVATION OF THE HEART.

An interesting series of observations, confirming those of Gaskell, have lately been made by E. Romberg and W. His, jun., on the innervation of the heart. These observers adopted the method of examining foetal hearts. The nerves of the heart begin to appear at the end of the first month. They arise from the wandering ganglion cells of the sympathetic system. The fibres which unite these cells with the sympathetic trunk run in companionship with branches from the vagus; with this latter nerve, however, the ganglion cells have no communication. Later on in foetal life, sympathetic ganglion cells are found in the walls of the heart itself. The cardiac nervous system, the formation of which takes place during the second and commencement of the third month, is formed as a plexus on the posterior

aspect of the ascending aorta (plexus aorticus profundus); this gives branches to the ganglia of the auricle, and also sends branches to a plexus, rich in ganglion cells, between the ascending aorta and ductus Botali (plexus aorticus superficialis). From the latter is derived the plexus coronarii. The ventricle has no ganglia. The cardiac ganglia, then, owe their origin to the sympathetic ganglia; these latter belong, according to the researches of Onodi, to the divisions of the posterior roots, therefore to the sensory tract. Thus the ganglia of the heart are also derived from the same source. The cardiac ganglia possess no motor functions; they are neither automatic centres for the heart, nor have any action in inhibiting or slowing the heart beat. If we accept the results of these observers as correct, the physiology of the heart's action can be satisfactorily explained. They point out that Render emphasises the fact that the heart of the embryo executes rhythmical contractions long before it possesses nerves or ganglia, and he is confirmed in his statements by the researches of Wooldridge. Concerning the function of the cardiac ganglia themselves, Romberg and his say little. They suggest that they possibly may transmit impulses to the central nervous system, which govern by reflex action the movements of the heart through the paths of the vagus and accelerans, and likewise regulate the calibre of the blood-vessels. If we must give up the idea of an automatic nervous system for the heart, we must provisionally accept as an explanation of its rhythmical action an automatism of the heart muscle, which may help to explain many of the anatomical and physiological difficulties which have never been satisfactorily disposed of. If these views be correct, the heart's muscle must be taken as the automatic motor power of the circulation, without deriving its movements from nervous elements. There has always been an uncertainty in ascribing certain irregularities of the heart's action to morbid con-

ditions of the ganglia, but is easier to imagine that the cardiac complications of typhoid and diphtheria are due to changes in the muscular elements than that the ganglia are at fault. The condition of the heart's muscle will now be a very important factor in the pathology of disease of that organ.—*Lancet.*

ASIATIC CHOLERA.

According to recent newspaper dispatches, a case has made its appearance in London. The patient in question was a coal trimmer on one of the steamers plying between Calcutta and that port. During the voyage he was able to attend to his work and showed no signs of being unwell; after landing, however, he became sick, was at large for a day or two, and was then admitted to the Poplar Hospital, where the disease was pronounced Asiatic cholera by the attending physicians. Upon investigation it was learned that after going ashore the patient wore some undergarments which he had brought with him from India, but which he had stored away during the whole voyage, and it was only after wearing these clothes that the disease manifested itself. As is usual upon such occasions as the present, there was a diversity of opinion regarding the true nature of the disease, the attending physician, it appears, maintaining that it was a case of genuine Asiatic cholera. The Local Government Board, after an investigation, concluded that it was not a case of Asiatic cholera, although it had many points in common with that disease. The patient did not die, so of course post mortem facts were not obtainable. Whether it was or whether it was not a case of true Asiatic cholera, the lesson to be drawn from this incident remains the same. The histories of the inception of epidemics of this dread disease in England, the northern countries of Europe and in this country are almost alike. That cholera is prevailing in India and along the shores of the Mediterranean, sufficiently to render

the rest of the world cautious, cannot be denied, and in these days when steam has brought all parts of the world so close together, and we are all familiar with the results of a visitation of this awful disease, the necessity for this caution is increased. Any country which, in the face of by-gone facts, neglects proper and thorough quarantine regulations, assumes a terrible responsibility. It has been stated that quarantine regulations are a detriment to commercial interests and do not have the desired effect; *i. e.*, they do not prevent the introduction of cholera. Such statements are eminently absurd, and it would be a most short-sighted policy for any set of men to pursue, even though they should lose entire sight of the human side of the question, and be actuated solely by avaricious motives. While quarantine regulations have not always entirely prevented the introduction of contagious and infectious diseases, they most certainly have done an immense amount of good. In 1867 there were fourteen epidemics of cholera at Staten Island, all of which originated from ships trading between New York and foreign ports, but of these fourteen only four reached New York, but a few miles distant, and it is probably not assuming too much to say that the methods then in vogue could be improved upon to-day. The first appearance of cholera on the American continent was 1832, and the history of this epidemic will conclusively prove to any well-balanced mind the value of a strict quarantine. During that year, five vessels filled with emigrants sailed at about the same time from different ports in Great Britain and Ireland, where the disease was then raging, the objective point being Quebec. Together they lost 179 passengers during the voyage.

The ships and their passengers were quarantined for a short time a few miles below Quebec, but on June 7th a steam-boat load was conveyed to Quebec and Montreal, most of them reaching the

latter city on the 10th, where a number dead and dying of cholera were landed. On the 8th the disease appeared among those who landed at Quebec, but over this whole stretch of territory, between Quebec and Montreal, a distance of two hundred miles, it made a single leap, appearing in only three instances and these were directly traceable to the steam-boat. In one of these instances a man used a mattress thrown overboard from this boat, and in the other two persons alongshore buried some dead from this same floating pest house. The town of Three Rivers, which is half-way between the above mentioned cities, did not allow the steamers to land there, escaped for a long time. Of course with Quebec and Montreal as the foci it did not take long for the disease to spread, but it is only reasonable to say that if the emigrants and ships had been placed under proper surveillance or had not been allowed to land at all that Asiatic cholera would not have found its way into this country through those channels. A disease which has left as a note of warning twenty-thousand corpses in one week, in a single city, which produces terror, alarm and complete stagnation in business circles, and which frequently leaves hardly enough well men to bury the dead can not be too closely guarded against.—*Gaillard's Medical Journal*.

THE ORIGIN OF MAN AND ANIMALS.

The arguments drawn from the experimental facts of variation and natural selection, from the observed progression of animal forms in successive geological strata, and the like, seem to me inadequate to explain the development of insects, fishes, birds, mammals, from one stock. Consequently, to my own mind it is a relief to be able to think of several, and, if of several, then possibly of any number of original germs. Let us then adopt provisionally the hypothesis of a multiplicity of germs of life; and if we do this, there is nothing wild or strange in the supposition that the germ of man

was different from other germs. It would be beyond all that scientific caution would justify to assume that, given a number of original germs of life, it is a matter of chance into what each will develop. It is contrary, I think, to the whole analogy of nature to suppose that a living germ, which is, to all intents and purposes, an ovum or egg, may ultimately develop into an oak, or a fish, or a man, according to its surroundings or according to mere chance. At all events, it is much more probable, much more according to analogy, that each germ should have its specific character, and that so man should have been man in intention and preparation from the very beginning of things.—From "Wallace on Darwinism," by the Lord Bishop of Carlisle, in the *Popular Science Monthly*.

THE QUICK PREPARATION OF SURGICAL GAUZES.

Helbing suggests the following method; Select a good raw material, perfectly free from fat, at least 30 threads each way in the square inch, and weighing about ten drachms to the square yard. This is about the average for good stuff. Take the necessary quantity of raw material, and weigh out a corresponding amount of antiseptic. The material is now saturated with ether or a mixture of alcohol and ether, in which the antiseptic has been dissolved, one ounce of the material requiring about 30 ounces of liquid. The gauze is several times wrung out and again saturated. For drying, the gauze is simply unfolded and shaken a few times. In this manner all the different gauzes may be prepared, carbolic, corrosive sublimate, iodoform, thymol, eucalyptol, etc.—*Gaillards Medical Journal*.

Medical Items.

Dr. J. J. Chisolm has returned home from Europe.

Dr. H. H. Biedler is at his office again. He spent the summer in Europe.

Dr. Robert Hoffman arrived from Europe this week.

There is to be an Academy of Medicine at Kansas City, Mo.

A Homeopathic Dispensary is building in Boston. It will cost about fifty thousand dollars.

Professor George J. Preston will deliver the introductory address at the College of Physicians and Surgeons on Monday, September 30th at 8 P. M.

Dr. J. Julius Richards of New Martinsville, West Virginia, a recent graduate of the University of Maryland, was in the city this week.

The Cecil County Medical Society has postponed its meeting until September 26th, the fourth Friday. Dr. John Morris of Baltimore will read a paper on "Puerperal Insanity."

The Turin Academy of Medicine has proposed the following theme for the Riberi Prize of about \$3,750: "Researches on the Nature and the Prophylaxis of One of Several Diseases of Man." Works may be sent printed or in manuscript; they may be in Italian, French, or Latin; and printed works must have appeared since 1886. The date limit is December 31, 1891.

The AMERICAN ASSOCIATION of OBSTETRICANS and GYNECOLOGISTS will hold its next annual meeting in the City of Philadelphia, on Tuesday, Wednesday and Thursday, September 16, 17, and 18, 1890, in the hall of the College of Physicians, corner Thirteenth and Locust streets. All physicians interested are invited to attend the general sessions.

E. E. Montgomery, President.
Wm. Warren Potter, Secretary.

The Delaware State Medical Society began its second century, on June 13th, at its 101st annual meeting in Wilmington. The election of officers resulted in

the choice of the following: President, Dr. Joshua A. Ellegood, of Laurel, Sussex County; Vice President, Dr. Ezekiel Cooper, of Camden, Kent County, Secretary, Dr. W. C. Pierce, of Wilmington; Treasurer, Dr. Joseph H. Chandler, of Centreville.

The *Medical Record* says:—In the Middle Ages, when men were perhaps more suspicious than they now are, it was a not uncommon practice of the groom to demand proof of virginity from his future bride. This was obtained in a perfectly satisfactory manner, and without offence to the young woman's modesty, by having her blow out a candle. If she succeeded in doing so at a single puff her honor was vindicated, but if she failed she had sinned, and as many puffs as the candle flame resisted so many had been her lapses from the path of rectitude.

Some time ago a hospital surgeon at Liège was cast in heavy damages, 10,000 fr. (\$2,000) in consequence of the somewhat unsatisfactory result of an operation performed on a child. The ground of the action was not that there had been any lack of care or skill, but that the operation had been performed without the consent of the child's father. The Court of Appeal has just heard the case and given its decision, which is contrary to that of the Court below, so that the defendant has at last had judgment pronounced in his favour.

At the recent meeting of the American Ophthalmological Society the following officers were elected: *President*, Dr. Hasket Derby, of New York; *Vice-President*, Dr. G. C. Harlan, of Philadelphia; *Secretary and Treasurer*, Dr. S. B. St. John, of Hartford, Conn.; *Corresponding Secretary*, Dr. J. S. Prout, of Brooklyn. The following were elected to membership: Dr. A. E. Ewing, of St. Louis, Mo.; Dr. Neil J. Hepburn, of New York; Dr. Charles M. Culver, of Albany, N. Y.; Dr. Richmond Lennox, of Brooklyn; Dr. Frank W. Ringl, of

New York. The Society then adjourned to meet with the Congress of American Physicians and Surgeons, September, 1891.

At the recent meeting of the American Otological Society the following officers were elected: *President*—Dr. Gorham Bacon, of New York; *Vice-President*—Dr. Huntington Richards, of New York; *Secretary-Treasurer*—Dr. J. J. B. Vermyne, of New Bedford, Mass.; *Committee on Membership*—Drs. Arthur Matthewson, of Brooklyn, Samuel Theobald, of Baltimore; and S. D. Risley, of Philadelphia; *Committee on Publication*—Drs. J. J. B. Vermyne, of New Bedford; Dr. C. J. Blake, of Boston, and Dr. J. Orne Green, of Boston. The following were elected to membership: Dr. Frederick L. Jack, of Boston; Dr. J. B. Shapleigh, of St. Louis; Dr. Benjamin J. Baldwin, of Montgomery, Ala.; Dr. J. M. Ray, of Louisville, Ky., Dr. F. W. Ring, of New York.

The Annual Reunion of the Pennsylvania and Maryland Union Medical Association was a very social affair. It was held at York last Thursday, August 28th, where several hundred guests gathered. Dr. I. C. Gable, President of the York County Society welcomed the guests; after him Drs. J. M. Deaver, John Morris of Baltimore, Packard of Philadelphia, and Mayor Noell of York spoke. After a hearty dinner the following officers were elected: *President*—Dr. J. J. Jamar, Elkton, Maryland. *Vice Presidents*—Dr. J. F. Packard, Philadelphia; Dr. J. Montgomery, Chambersburg. *Secretary and Treasurer*—Dr. T. S. Livingston, Columbia. *Executive Committee*—Dr. Alexander Craig, Columbia; Dr. J. A. C. O'Neil, Gettysburg; Dr. S. J. Rouse, York; Dr. W. T. Bishop, Harrisburg; Dr. W. W. Dale, Carlisle; Dr. H. C. Whiteford, Darlington, Maryland; Dr. John Morris, Baltimore; Dr. Ewing, Chester. Besides Dr. John Morris, Drs. George H. Rohé and Wm. B. Cafield were present.

MARYLAND MEDICAL JOURNAL.

VOL. XXIII. No. 20. BALTIMORE, SEPTEMBER 13, 1890. NO. 494

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MEDICAL ITEMS.

Original Articles.

CLINICAL OBSERVATIONS ON SALPINGITIS.*

BY THOMAS A. ASHBY, M. D.,
OF BALTIMORE.

Fellow of the American Gynecological Society,
Professor of Gynecology in the Baltimore
Medical College, etc.

By the term salpingitis is meant an inflammation of the mucous membrane lining the Fallopian tube. The disease may run its course in an acute, subacute or chronic form. Its results depend largely upon its extent, severity and manner of behavior, since it may exist in so mild a form as to occasion little local or constitutional distress, or may develop a most virulent type, resulting in death or grave impairment of health. Salpin-

gitis has been recognized by pathologists and clinicians for many years past, yet strange to relate it attracted comparatively little attention, and was not regarded as a serious ailment until within the past few years. Its results were not viewed with serious significance until the development of modern intra-pelvic surgery brought to light the fact that intra-pelvic inflammations and pus accumulations could be traced to this source of origin in the vast majority of cases. The entire field of intra-pelvic pathology has been worked over and re-explored since frequent incursions into the pelvis have been brought into practice in the treatment of intra-pelvic disease. We owe to modern abdominal surgery our present knowledge of the origin and behavior of intra-pelvic inflammations. Only a few years back, it was the custom and practice to treat all intra-pelvic inflammations under the classification of pelvic cellulitis and peritonitis, or as Virchow designated them, "parametric

*Read before the Washington County Medical Society at Hagerstown, Md., August 13th, 1890.

inflammations." The origin, progress and treatment of such inflammatory troubles were wholly misunderstood and incorrectly interpreted. We were vaguely groping in the dark and striking at unknown etiological factors and pathological expressions. Our treatment of such conditions was correspondingly inefficient and unsatisfactory. When the surgical mind was turned in the proper direction, and through rational methods of exploration began to seek the true nature of these intra-pelvic inflammations, it was at once discovered that salpingitis lay at the root of these conditions, and that its results were evidenced in conditions which were often removable by the knife. Here the knife exercised its supremacy, and relegated to the background the so-called antiphlogistic regimen handed down from our forefathers. When once the ball was put in motion its revolution became complete and such reforms have followed both in our knowledge of the pathology of intra-pelvic troubles and in the treatment of the same that we stand to-day in the midst of a complete revolution of opinions and of practice in relation to such conditions. As recent as this revolt from ancient dogmas has been, it has been attended with such decisive results that all unprejudiced men will at once accept the conclusions reached. To one who has worked within the pelvis and who has carefully studied the pathology of this region through his laparotomy work, the important rôle which salpingitis plays in the causation of intra-pelvic inflammation is unmistakable. We may trace to this etiological influence the most striking, significant and disastrous results. To my mind the whole chain of cause and effect is complete and we are able to account for symptoms and conditions as successfully as we can recognize through auscultation the destructive influence of inflammatory troubles within the thorax. To reach the facts in our investigation, we would begin with salpingitis in its primary stages and then trace it step by step to its final results.

As to the origin of tubal inflammation we have positive data to guide us. Lined with an epithelial membrane, and differing in no marked particular from mucous membranes in other organs, we are not surprised to find the tube exposed to ordinary inflammatory diseases. It is a mere extension of the lining membrane of the uterus only differing in its anatomical structure and glandular apparatus hence inflammations which involve the endometrium very readily pass by continuity of tissue to the tubes. It is therefore not unlikely that ordinary catarrh which extends from the cervix to the uterine cavity, involves the tubes in a large number of cases, and may account for those minor forms of intra-pelvic pain which have been referred to as uterine catarrh. It is my belief that so-called uterine catarrh as a distressing symptom has been exaggerated, and that the pain associated with these cases should be referred to corresponding troubles in the tubes and broad ligaments. In our severe punishment of the uterus with caustic applications, we have overlooked the tubes, and to that extent fallen short in giving complete relief to symptoms; not only so, but in referring many cases of sterility to uterine influences we have in like manner overlooked the possible existence of a mild salpingitis just as capable of defeating the intent and design of the reproductive act.

My experience and observation teach me that minor tubal inflammations are frequently over-looked in the diagnosis and treatment of intra-pelvic symptoms, and that we vainly punish the uterus with unnecessary local applications when the source of trouble is in the tubes and broad ligaments. It is quite true that we are not able to determine the minor conditions with positive certainty, but we can arrive at them by correct principles of treatment quite as surely as by the touch and methods of exploration. In my opinion, uterine catarrh is, comparatively speaking, a harmless condition in the absence of uterine displacement and tubal inflammation. The uterine

glands weep as freely under ordinary catarrhal conditions as the nose, and the results are similar.

We can not accurately determine the extent and influence of a local inflammation within the uterus by the discharge of mucus from the canal.

The treatment of these minor intra-pelvic pains is most successful when based upon a rational interpretation of the origin of such symptoms. Reposition of the uterus and appurtenances if depressed in the pelvis, absolute rest, for the time being, from violent or prolonged physical exertion, the faithful use of hot water injections and withdrawal of all sexual stimulation, do far more good than local applications. I do not wish to underrate the value of local applications judiciously employed, but I am satisfied this method of treatment is overdone both in the energy of the treatment itself and in the strength of the agents employed. Beyond the thorough cleansing of the canal and cavity with mild astringent and antiseptic solutions, and the opening up of thorough drainage, I think we are rarely justified in going, except, of course, in those extreme cases of endometritis, where the evidences of inflammatory action are very apparent.

Recognizing the fact that salpingitis originates from the extension of an endometritis, whatever origin this latter may have, we learn at once the influence it may exert upon the subsequent condition of the tubes, ovaries, and pelvic tissues in general. Omitting from our consideration the ordinary catarrhal troubles of climatic or constitutional origin, there are two diseases which affect the tubal mucous membrane with singular power and viciousness. The first, and perhaps most frequent condition, is a septic process following labor, miscarriage, or surgical operations upon the uterus. Each of these influences is capable of causing a most virulent salpingitis, which may wind up in total disorganization of the tube, or extending along the tube into the pelvic cavity kindles a violent pelvic peritonitis almost disastrous to the pelvic tissues, if not fatal to the woman. Sep-

ticæmia of immediate or later origin may follow the conflagration of tubal inflammation and destroy the woman within a few hours or days. The so-called puerperal fevers originate after this manner with an underestimated frequency. I have seen within the past three months, in consultation, two cases of undoubtedly septic endometritis following labor at full term in which the tubes became involved secondarily and intra-pelvic inflammation exposed the life of each patient to imminent danger. Upon examination and thorough cleansing of the uterine cavity, thorough drainage and disinfection, and removal of septic material, the local inflammation promptly subsided and pus formation was arrested. One circumstance arrested my attention in these two cases as it had frequently done in the more chronic forms of tubal disease which I had met with. This was the presence of a badly lacerated and ragged cervix with sloughing surfaces and copious sanguous discharges. This condition of the cervix, to my mind, explained the origin of the septic process and its extension to the endometrium and tubes. I have observed as the invariable rule that in every case of tubal disease which I have seen in women who have borne children, there was present an old cervical laceration, and I am prepared to believe that the tear of the cervix was the origin of the salpingitis in these cases; not only so but I feel justified in going farther and in saying that cervical lacerations are accountable for the vast majority of cases of tubal disease, from which I, of course, except those of a gonorrhœal origin. The extension of the disease from such a focus of infection seems eminently rational. Dr. Emmet has shown that lacerations of the cervix heal by primary intention in the vast majority of cases in which septic material has not gained entrance to the wound, and thus defeated the primary union. An old laceration bears upon its very face the evidence of a septic process, which may have expended its violence in the local wound, or may have extended along the

uterus to the tubes and there wrought further damage. My experience with lacerations of the cervix has been extremely satisfactory. There is no plastic operation within the pelvis which brings such uniformly good results, and yet I meet with cases in which the tear is insignificant upon the health of the woman in comparison with the tubal disease which co-exists. To repair such a cervix is of little value until the tubal disease has been removed. Whichever procedure is instituted first, the health of the woman is not restored until both lesions are cured. And this leads me to another observation. We all meet with cervical lacerations of years standing which occasion no inconvenience whatever to the woman. She is positively unable to recall a single symptom of intra-pelvic pain or of reflex disease. Did not some of these women unfortunately fall into our hands late in life with cancerous developments, we would never know that a laceration existed. How are we to account for this condition of affairs? The explanation which has forced itself upon my judgment is, that in a large percentage of cases the lesion in question is more pronounced in its influence upon the nervous system of the woman just in proportion to the extent of tubal disease which co-exists. I am not prepared to say that in all cases of laceration there is a tubal disease, but the association of the two affections in the same woman is too apparent in many cases to admit that the cervical lesion does exist in some cases pure and simple, and that the repair of this lesion results in a positive cure of the woman. The point I wish to lay stress on is this, that a tear of the cervix during parturition is often a starting point of septic infection, which involves the endometrium primarily and then establishes a salpingitis with its sequelæ and results.

The importance of recognizing this fact is self evident. It is at this status of the parturient act that those precautions should be exercised which not only

lead to a primary union of a torn cervix, but which should prevent auto-sepsis as well as hetero-sepsis. By the use of clean hands, clean instruments, and thorough antiseptic precautions, we may intercept that chain of events which culminate in salpingitis and general pelvic inflammation. If prevention is more important than cure, we should recognize the conditions which establish pathological influences and cut them short *in embryo* as it were, and before disastrous results have been established.

One only has to study the etiology of salpingitis to discover the correctness of the views here expressed. By far the most frequent causes of salpingitis, are the influences I have referred to, just as salpingitis itself is the next step in the causation of destructive tubal disease and intra-pelvic inflammations.

Apart from the septic processes here referred to, gonorrhœa is a potent influence in the causation of salpingitis. The specific influence finding its way into the uterus, passes on to the tubal mucous membrane and here arouses active inflammatory trouble. It may expend its influence in an acute or chronic attack and result in resolution with simple impairment of the tubal mucous membrane, or its most virulent forms may culminate in pelvic peritonitis, or what is now so often met with, in the pus tube. Gonorrhœal salpingitis is far less commonly met with in my experience than the septic varieties. It is most usually found in prostitutes or uncleanly women of menial birth and occupation. Now and then it is observed in the purest of women under circumstances of peculiar distress. I have met with a number of cases among this class, in which its origin and effects were clearly traceable to influences which were so unmistakable as to leave no doubt as to the correctness of the diagnosis. A latent gonorrhœa in the husband becomes re-established under the exercise of the marital relations and without the knowledge of husband or wife the latter is infected. Soon

symptoms are established which point to unmistakable proof of intra-pelvic inflammation. These cases assume all shades of severity and culminate in various forms of intra-pelvic disease. The milder varieties become hopelessly sterile, whilst those of a more severe form evolve the pus tube, intra-pelvic peritonitis, chronic ovaritis, and other evidences of damaged pelvic tissues. Various causes are assigned for the origin of such symptoms, but the careful clinical observer detects the hand writing on the wall, and very soon establishes in his own mind the proper relation between cause and effect.

Without dwelling at any further length upon the etiology of salpingitis, I shall pass to a consideration of the clinical features of this affection.

In the acute form, salpingitis is so often associated with metritis, endometritis, and intra-pelvic inflammation that it is not easily distinguished in its clinical history from these affections. So far as its treatment is concerned, the refinements of diagnosis are not essential. We find in these cases all the evidences of intra-pelvic inflammation. There is pyrexia, pelvic pain, tenderness upon pressure, intense heat of the vagina, immobility of the uterus, and often rectal and vesical tenesmus. In some cases where the tubes are largely involved, the sausage shape and feel of the tube can be made out. Unless pus exists in a large quantity, fluctuation is not marked. The physical signs are those of a tense, dense and compact swelling and fullness of the regions around the uterus, with depression and fixation of this organ. The signs correspond very closely with those we have been in the habit of attributing to parametric inflammation, the old pelvic cellulitis. I am inclined to the opinion that in these acute attacks we cannot be positive whether we are dealing with a lymph deposit, pus accumulation in the cellular tissue or swollen and distended tube, until the progress of the case gives evidence of the exact behavior of the inflammatory deposit. If it is lymph we have to deal with, reso-

lution will cause its absorption under favorable method of treatment; if it is a phlegmon, fluctuation becomes more distinct, and pus finds an escape through some artificial or natural outlet. If the pus remains encapsulated, as it were, or a sausage-shaped tumor shows itself in the region of the broad ligaments, we may rest assured that we are dealing with an enlarged tube or pyosalpinx.

I know of no clinical condition so misleading as the one under consideration, and I claim that here the diagnosis is a matter of far less importance than the line of treatment to be pursued. The symptoms indicate either mild or grave constitutional disturbance, and just as these indications point, should a line of conduct be adopted. If we have great pyrexia, intense pain, and evidences of pus formation and pus absorption, an outlet for pus should be made at once, by the most feasible route to secure drainage. Many of these conditions have been treated successfully by aspiration and vaginal drainage. This method is open to consideration. I, however, hold to the opinion that where our patients are properly situated for an abdominal section, the abdomen should be opened and the pelvis cleaned out. A laparotomy enables the surgeon to detect the exact location and nature of the inflammatory tumor, and to remove it.

The one important question which arises in these cases, is when to do a laparotomy. I know of no clinical question so difficult and so important to decide, from the simple fact that so many different factors are presented for consideration. The present condition, surroundings of the patient, and skill of the operator might favor an expectant plan of treatment in one case which would invite a course of immediate action, were the conditions reversed. I may say here that experience with pelvic inflammations has long since proven that salpingitis and pus accumulations in the pelvis are not necessarily fatal affections. Many women can, and do pass through gravest perils and come through acute attacks

with fairly good results. No two individuals are affected exactly alike, and no two obtain like results. Hence we find the pelvic organs and tissues involved in many ways after the conflagration has passed over them. In one case the tubes are chiefly involved, in another the ovaries, and in another the pelvic peritoneum. In some place, if not at every point, we find evidences of the fire and the remains of its influence. She is an exceedingly fortunate woman who has a salpingitis with complete recovery and no lesions. Such cases do occur but they are few and far between. We may, on the contrary, confidently expect a serious lesion of the pelvic organs as a result of a severe salpingitis, and this fact bears in a measure upon our line of treatment. In acute attacks we may hesitate in regard to a laparotomy and wait for very dangerous symptoms to drag us into the employment of this procedure. In the more chronic varieties where evidences of pus, or of old chronic intra-pelvic inflammations and lesions exist, we should not hesitate to open the abdomen and remove the tubes, ovaries, and damaged tissues. This is the only way to dispose of them. It is either this or a palliative regimen which begins in the present and ends in futurity. It is a principle of surgery that pus should be removed whenever and wherever it exists, if its removal can be accomplished within the limitations of a legitimate surgical procedure. This rule applies to pus in the pelvis. If the pus is in the cellular tissues, it will most likely burrow and escape by some route of its own selection, if one is not made by the surgeon. The most natural route for these accumulations is the vagina, yet they often open elsewhere. If nature or the surgeon provides good drainage, the pus tract will close spontaneously, and recovery may be expected to follow. A cellulitis is a phlegmon and runs an acute course. This clinical history does not apply to pus which becomes encapsulated in the tube. A pus tube is evolved in a gradual way. They

may be weeks, months, or even years in developing. I removed one in September last which I am convinced was over four years in reaching the size and condition found at its removal. They go on developing either rapidly or slowly, until a point is reached where rupture takes place, pus is discharged and dangerous symptoms are aroused. The violence of the explosion is problematical. Nature has some fanciful way of taking care of these people under these circumstances, for they tolerate pus, bear pain and hold on to life in a way that is surprising. A few die very promptly, but others are honeycombed with pus cavities and outlets, and die from slow septicæmia and adynamia.

The point I wish to make clear is this: never wait for a pus tube to rupture and make its own outlet for drainage. If the route is by the rectum or bladder the removal of the tube by a laparotomy becomes at once a most hazardous performance. In our attempts to remove a pus sac under such circumstances we may remove the rectal or bladder wall and thus make the latter state worse than the first.

A rule which I would lay down for observance in the management of salpingitis and its results, would be to keep a rational regard for symptoms and indications and to place a clear interpretation on them. Whatever we have to deal with, whether pus, adhesions, or damaged ovaries and tubes, we should attempt to remove them before our patient is worn out with months and years of invalidism, and before they have established such relations to surrounding organs as to make their removal extra hazardous and next to impossible. The mortality following surgical methods of treatment in such cases is traceable in largest measure to the delay and hesitation which postpone interference from day to day, until the operation becomes a final resort or forlorn hope. A prompt decision and judicious course of action will give results which appear astonishing to the uninitiated. The danger of operation is not from the

operation, *per se*, but in the conditions which have to be overcome through the neglect and delay in instituting the operation.

1125 Madison Avenue.

TWO CASES OF SUFFOCATIVE GOITRE*

BY J. W. HUMRICHOUSE,
OF HAGERSTOWN, MD.

In the afternoon of January 3rd, 1886, G. F. a young man 17 years of age, born in Hagerstown, came to consult me about a swelling in his neck. Lately this swelling had increased so much that he could not button his collar. He had also for three months suffered severely from attacks of difficult breathing, which came on in the night. His father and sister had slight enlargement of the neck, but it gave them no trouble. The young man was well developed, had neither heart nor lung disease; his voice was not affected, and his breathing was good. An enlargement of the thyroid gland was observed large enough anteriorly to press against the neck band of his shirt. The tumor was not measured, but its apparent dimensions were moderate. A careful laryngoscopic examination did not disclose a bending in of the tracheal column nor any cause for the dyspnœa. The two striking symptoms of the case were the paroxysms of dyspnœa and the swelling of the thyroid gland. The young man left my office, and at 7 P. M. took the train for his home. The same night he was seized with an attack of dyspnœa in which he died.

The second case was seen with Dr. Steck. The lady, aged about fifty, living for many years in one village, had had a rather large goitre which she had had for many years, and to which she had attached no importance. The tumor was not large enough to be disfiguring. She suffered with attacks of difficult

breathing, the cause of which she regarded to be her lungs. No obstruction to the passage of air could be seen with the laryngoscope, and examination of chest gave only signs of a bronchitis of moderate severity. A short time after I saw her she died in a paroxysm of dyspnœa.

The disastrous termination of these cases, and the common occurrence of goitre in our country have induced me to bring the subject before the society.

That sudden death is liable to occur in cases of moderate enlargement of the thyroid gland, associated with paroxysms of dyspnœa, and unaccompanied with tracheal stenosis, may be inferred from the history of these two cases. It is liable to occur because we cannot with certainty, either medically or surgically, remove its cause. In the cases above mentioned the absence of any visible narrowing of the windpipe together with the intervals of easy breathing show that no permanent obstruction to the passage of air existed. On the other hand, the paroxysmal character of the attacks indicate their nervous origin. The recurrent laryngeal nerves ascend the neck between the trachea and oesophagus, close beneath the posterior portions of the lateral lobes of the thyroid gland, and are distributed to nearly all the muscles of the larynx. Compression of these nerves causes paralysis, especially of the abductor muscles, and such an approximation of the vocal bands that breathing becomes greatly impeded, so much so, sometimes, as to produce death. This we regard as the cause of the fatal issue in our two cases.

To show the dangerous character of suffocative goitre, we will review three cases treated in the Pennsylvania Hospital and reported by Dr. John B. Roberts. The first under the care of Dr. Morton was one of cystic bronchocele of many months standing suddenly taking on rapid growth and causing death. When the patient was admitted, the neck from the centre of one sterno-mastoid muscle to that of the other measured six and

*Read before the Washington County Medical Society at Hagerstown, August 13th, 1890.

one-half inches, and the verticle measurement was three and three-quarter inches. In the last three months of the patients life, the tumor had increased so much as to interfere with respiration and deglutition so much so that he could not lie down and could hardly take nourishment. The post-mortem showed the presence of a cyst, the transverse circumference of which measured seven and a half inches, and a narrowing of the trachea to one-half its calibre. In this case, although under the care of Dr. Morton, medical means were alone adopted. The narrowing of the trachea was not considered sufficient to cause death which was supposed to be due to exhaustion.

The second case was one of acute bronchocele producing death by asphyxia in three weeks. The patient aged 18 was admitted to the hospital July 5th, 1875. He stated that about the middle of June he buttoned his collar with difficulty. The following day his throat had increased in size so much that he could not button his shirt. When admitted the tumor was the size of a cocoa-nut and his respiration was embarrassed, though he could eat his dinner and afterwards he walked in the yard. There was no cardiac murmur. In the afternoon a violent paroxysm of dyspnœa occurred, which soon abated, but he grew worse and his labored respiration could be heard for a long distance through the house. The attacks of dyspnœa became more and more frequent and tracheotomy was suggested but deemed useless. The patient died cyanosed the morning after admission. The specimen obtained at the autopsy weighed four pounds and measured with the enclosed trachea six and three-quarter inches. In this case tracheotomy was suggested but deemed useless.

The third case was an acute bronchocele with cardiac hypertrophy occurring during pregnancy. The woman was admitted on account of paroxysms of dyspnœa. There was a slight prominence of the eyes, and an enlargement of the

thyroid gland on the right side, where the tumor was, about the size of a large egg. There was no heart murmur. Respiration was labored, there was harshness of voice, and three or four times daily the dyspnœa became so aggravated that the woman was almost asphyxiated. During these paroxysms which lasted three or four hours she screamed, threw her arms about and struggled for breath. Dr. Cohen by the laryngoscope found tumefaction of the arytenoid cartilages, and saw that the glottis was not oedematous but that although vibrating spasmodically it did not close as much as normal. There was also bulging inward of the tracheal walls. It was decided to undertake some operation, and accordingly laryngotomy was done. Although this was performed, and the operator could force his finger into the windpipe, thus dispelling the idea of stenosis, yet the patient's breathing was much embarrassed, and finally she died 29 hours after the operation. The autopsy showed that the tumor measured eight and a half inches with trachea in circumference, and at the sides reached as high as the larynx. The tracheal wall was slightly pushed inwards and the tumor had to be dissected up in order to expose the recurrent laryngeal nerves which are beneath it. In this case the operative procedure was of no avail. Dr. Roberts thinks this last case belongs under the head of Grave's disease but that the fatal dyspnœa is to be attributed to a thyroid rather than a cardiac origin on account of the absence of distinctive heart symptoms. The cause of death he regards to have been pressure by the tumor on the recurrent laryngeal nerves. In none of the cases was the dyspnœa considered as due to stenosis of the trachea because the narrowing of the windpipe was not sufficient to have caused it.

These five cases show the little avail of medical or surgical means to ward off a fatal issue in suffocative goitse. It consequently behooves us to consider the means to be adopted to prevent the growth or to effect the removal of goit-

trous enlargements in order to prevent the possible future development of dangerous symptoms. The first and most important of these means is to change the place of residence of the patient. It is undoubted that geological and climatic conditions are important factors in the production of goitre. It is a disease endemic in the Alpine valleys of Switzerland, Italy, in the Pyrenees, in the Hartz mountains and Black Forest of Germany, in the Himalayas, in the Andes of America, and it appears frequently enough in the Cumberland valley to be regarded as belonging to its mountains and valleys. In some places it also occurs as an epidemic. In one instance of this kind, fifty-three cases occurred in a regiment of 1062 men after six months stay at Briançon. In another instance thirty per cent. of the members of a regiment were attacked with swelling of the thyroid body which only disappeared after removal from the district. This local endemic and epidemic character of the disease points strongly to local causes. What the specific local cause is has not yet been ascertained.

Humboldt found goitre in South America at all elevations, in thick forests, in soils destitute of vegetation, in extremely damp places and also in dry places, where the wind was impetuous and where the air was stagnant, in some regions where the temperature all the year round was between 71° and 73° , and in others between 37° and 62° . As to water, it was chemically pure flowing over granite in some places, in other instances it issued from rocks of free-stone or lime. One recent theory is that a local exciting cause exists of a miasmatic nature, independent of altitude or temperature, but developing only over certain kinds of rock or soil. Bircher believes it occurs only on marine deposits of the palæozoic, triassic or tertiary age. The oldest and most popular doctrine makes goitre and cretinism depend on drinking-water rich in lime salts. It has been indeed proved that the diseases occur for the most part upon limestone and do-

lomite soil, the latter or magnesian-limestone rock being the more important of the two. But on the other hand the disease prevails also where the water is free from mineral salts. In our country we find goitre in the valleys and along the mountains, among people who drink hard water and those who use soft. It is a limestone country with slate here and there, and also with upheavals of rock forming our mountains which belong to early geological periods. Just over the South mountains in Middletown valley, we find no limestone nor hard water, but a great many cases of goitre. Although impossible to give a specific cause for goitre, it is certain that it is an endemic disease, and consequently change of residence should always be advised. It is never found close to the coast. In our endeavor to treat the disease by removing the causes which produce it, we must recognize as a fact that it is largely of hereditary origin. Thus Vetlesen formed in each of one hundred and seventeen families of Hamar Norway one or more members with goitre. We have found in our cases that other members of their families were affected.

The intermarriage of people having goitre and living in a goitrous district certainly is a factor in the development of the disease. Poverty, want of proper food, anti-hygienic conditions, are also adjunct causes in the production of goitre. It has been observed in manufacturing towns in England that as the general condition of the people improved in sanitary and other respects, that the disease became less frequent. In deference to the view that drinking water containing earthy salts is a cause, only that free from such salts should be used. Boiled water would be indicated if we believe in the miasmatic origin of the disease.

The medical means relied upon in this disease consist almost entirely in the use of iodine. It should be used in the early stages and in small doses for a long time. Three to five grains of potassium iodide, syrup of hydriodic acid in half or tea-

spoonful doses, or where there is anæmia syrup of iodide of iron or Blancard's pills of protoiodide of iron are available preparations. Inunction of iodine ten grains or more to the ounce of lanoline, or an ointment made by dissolving one ounce of potassium iodide in one ounce of water, and then incorporating the solution in one ounce of lanolin are useful external applications. Cohen recommends the use of a saturated solution of iodoform in ether, chloroform or collodion. The last solution would serve a useful purpose by compressing the tumor by means of the elastic coat which forms upon evaporation.

The most frequently used surgical means in the treatment of goitre has probably been the injection of tincture of iodine. It is used where the growth is of a fibroid nature being made of connective tissue chiefly, or where it consists principally of hyperplasia of the glandular elements. One-third or one-half of a syringeful of tincture of iodine is injected into the substance of the tumor once a week for a varying length of time, in some cases for many months. Of course bloodvessels must be avoided in these injections as instant death has followed the perforation of a vein.

Dr. Heyman of Berlin at a recent Congress of German Physicians and Naturalists reported the case of a woman in whom a goitre had diminished to one-third its former size, after injections of iodine practised once a week for four months. After the last injection there were great pain, vomiting, loss of consciousness, contractions and finally death. Heyman had collected sixteen recorded cases of death after parechymatous injections. Billroth in his "Allgemeine Chirurgische Pathologie and Therapie" says in the first case he used injections of iodine, he had no result. In one case, in which he used alcohol, the patient died from suppuration and septicæmia. He does not recommend the use of injections in weak or tubercular persons on account of the drain on the strength which their employment for a long time occasions.

For cystic goitre the usual treatment is drawing off the fluid with a trocar and canula, and then refilling the cyst with a solution of iron tincture of the chloride 3 ii, to water 5 i, or with tincture of iodine. The object is to produce suppuration and obliteration of the cavity. This same end is sought by the insertion of a seton.

Electrolysis has also been used to destroy and produce shrinking of the growth. Ligature of the thyroid arteries is another means to bring about a gradual reduction in size.

The most radical procedure in the partial or entire removal of the gland. According to Keen, of Philadelphia, in a late number of *The Medical News*, there are three procedures to effect this. The first is evacuation and consists in opening the various loculi whether cystic or solid, and peeling out their contents. The second method is enucleation, and consists in cutting down to the cyst itself and enucleating it. The third method is extirpation, which is most dangerous of all methods both in immediate and remote results. Socin in 59 cases of evacuation and enucleation had only one death. He used 170 ligatures in the fatal case. Kocher in 225 cases of extirpation had only two deaths. Keen, in his case of enucleation used 37 ligatures; his case recovered entirely although for six days seriously ill with septic fever.

Notwithstanding the brilliant immediate success of extirpation, partial or complete, the trend of opinion, according to Dr. Rex, is against the operation on account of the development of a cachexia afterwards. It is only when other means have failed and there is danger to life, that the operation of partial removal is justifiable. Total extirpation should not be performed, because followed by a condition called by Professor Kocher of Bern, *cachexia strumipriva*. In this state, patients become inattentive, falling asleep when talking to anyone, and show slowness in all mental actions. The skin becomes thickened, lips en-

arged, nose broadened, and awkwardness of movements is also observed. The symptoms resemble so closely those of myxœdema and cretinism that the three diseases are now considered as one disease, or rather as different aspects of the same disease. On account of their following extirpation of the gland, the absence of that organ is regarded as a cause for their existence. The prevalence of cretinism in goitrous districts is also explained by the diseased condition of the thyroid gland.

CHRONIC ABSCESS.*

BY L. K. BEATTY, M. D.,
WASHINGTON D. C.

My excuse for bringing to your attention at this time the above subject is the fact of the recent colored case reported by Sir Joseph Lister in his recent paper on the subject of his new surgical dressing of the so-called double cyanide of mercury and zinc, and also my very poor results under the now old method of using bichloride dressing.

Cause.—The cause of this condition is said to be found in irritations formed by the deposit of tubercular matter; a renal calculus; the occlusion of an artery cutting off the supply of blood to apart; or in fact from any cause which will supply the necessary nucleus for starting the suppurative process.

Symptoms.—Of symptoms, we have in the early stages absolutely no evidence which would call attention to the condition of existing abscess.

There is absence of chill, or local heat; in fact it is seldom recognized until we are called on to differentiate between it and soft tumor which of course the grooved needle or trochar makes a very easy matter.

Case.—J. S., bookbinder by trade, white, aged about fifty, called at my office in the early part of September 1886

to consult me about an enlargement over the outer aspect of the thigh which he said had been giving him trouble for some time. He was a vigorous strong man, in middle life, and well nourished. The growth had not been rapid, but at this time occupied about one-third of the space from the hip joint to the knee well defined and tense so that my diagnosis was only made certain by the use of a small trochar; from its location in the external aspect of the thigh, I concluded it must have been the result of an old injury to the bone at or near the hip-joint, but could get no history of injury from him except a possible fall years ago, which was too remote to have much consideration in making a diagnosis. The general appearance and otherwise good health of the patient would exclude a tubercular origin and the well nourished condition of the part appeared to me to exclude a thrombic origin, so by exclusion I based my diagnosis on an injury to the bone.

At this time he was making full time working at his trade in the Government printing office. I directed him to continue his work, telling him at the same time the probable result of opening the abscess freely, namely that for some time, and probably for all time, he would not be able to continue at his usual work; and at the same time directed the external use of tincture of iodine and gave him tunic treatment.

For the next four months I kept Mr. S. under observation and treatment, he, during most of the time, making full time at his work.

Early in January 1887, the abscess had very much enlarged and made trouble for him. It now extended over about two-thirds of the thigh, and as he described it was "a very unhandy attachment to carry around;" so, at my suggestion, Dr. J. Foard Thompson was called in consultation. Dr. Thompson decided that it should be opened at once and dressed antiseptically, so, on January 8th 1887, Dr. Thompson made a free incision which was followed by the

*Read before the Clinico-Pathological Society of Washington, D. C., January 21st, 1890.

escape of a large amount of accumulated matter, and the discovery of a very thick limiting wall, which wall I regret to say there was no effort made to remove, the opening having been made in the most dependent portion of the abscess it was not possible to explore it to the full extent, and as a result my diagnosis was not positively confirmed.

Treatment;—The sac was thoroughly washed out with bichloride solution, drainage tubes inserted and the wound dressed with antiseptic gauze. This dressing was removed every 48 hours for some time. In connection with these, stimulants and wines were used freely, and at the end of about four weeks he returned to his work.

For the next nine months the antisепtic dressing and other treatment was very faithfully followed, and Mr. S. was able to be about and made at least two-thirds of the usual time at his work; when in the following October a homœopathic practitioner of this city kindly relieved me of my troublesome patient by calling on him and promising him that by his method of treatment he would enable him to make full time at his office, which promise I am able to say has not been fulfilled as I have seen Mr. S. a number of times since he left my care. He tells me he has not been able to do any work since the antisepctic plan of treatment was abandoned. Now as to the treatment of this case, I am confident the antisepctic plan, as understood at that time, was faithfully followed, during nine months after the opening was made. The general treatment was tonic, stimulant and nourishing, and still the usual results followed, the hectic condition and loss of tissue followed.

The *Medical Record* for November 23rd, 1889 published a paper by Sir Joseph Lister, in which he explains at some length his new antisepctic method of surgical treatment of wounds, etc., by his so-called double salt of cyanide of mercury and zinc, and at the end of the paper alludes to a case of psoas abscess which he claims to have under treatment,

and which is making remarkable progress under the use of his cyanide gauze. This patient instead of developing the hectic condition of fever and general loss of vitality which we are so well acquainted with and so surely look for, has, to quote the words of Lister, "put on flesh rapidly." "In this man's case the temperature has never been affected in the least, he has put on flesh rapidly. The discharge after the purulent and curdy matter that existed originally in the abscess was got rid of, has been of serous character, and is in small and diminishing quantity."

This report is of a very rosy hue that before I would advise one to put confidence in it, I would like to see the true clinical facts, not in a general way as Lister has given them but with the thermometer and scales.

TREATMENT OF SYPHILIS BY RECTAL INJECTIONS OF IODIDES.

According to the *Revue Générale de Clinique et de Thérapeutique*, the following formula may be used by the anus, whenever the stomach is disordered:

R.—Iodide of potassium 15 grains.
Extract of belladonna $\frac{1}{4}$ grain.
Water 4 ounces.

—M.

The solution must be warm, and is said to be well borne and effective.—*Medical News.*

A French student's impressions of German university life are given in brief in the *Lyon médical*. One reaches Germany he says, with the idea that the studies there are very hard, and that the German students do more work than the French students; but one presently dismisses this idea, and gets the notion that the German students hardly work at all. On further acquaintance with them, however, it appears that in a German university, as in any other, there are those who work little and those who work much, the former masking the latter because more is seen of them.

MARYLAND MEDICAL JOURNAL**Weekly Journal of Medicine and Surgery.****WILLIAM B. CANFIELD, A.M., M.D., Editor***Subscription \$3.00 per annum, payable in advance.*

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BALTIMORE, SEPTEMBER 13, 1890.

Editorial.**SLEEPING WITH THE WINDOWS OPEN.**

There are certain persons in every community who are ever ready to extol the custom of sleeping with the chamber windows open. Not only do they ascribe to this habit their own health and robustness, but they are perfectly confident that they should "smother" if they closed the windows. Furthermore, they are very active in propagating their views, and consider that their neighbor who confesses to an occasional closing of the windows even in summer is not only making himself effeminate, but is actually violating the principles of cleanli-

ness. Under these circumstances, it is no wonder that they remain masters of the field of discussion and that their doctrine comes to be accepted by the community.

Now, it is plain to any observant physician that people—even when in the best of health, differ greatly in their ability to bear great and sudden atmospheric changes. This difference appears to depend chiefly on the structure or functions of the skin, which varies greatly in its resisting power from hereditary peculiarities or acquired feebleness.

There are in every community persons who are very little affected by atmospheric changes. Sudden chilling of the skin by cold draughts or exposure to atmospheric changes produces little or no effect upon them, because the skin is in excellent condition, well oiled and ruddy, and, when chilled, reacts quickly and is in a moment warm with swiftly circulating blood. These persons are generally in excellent health, but, although less subject to chilling than their neighbors, are not necessarily less prone to diseases which assault the body in other ways.

There are other persons, and very many of them, who even when in ordinary health, are very sensitive to chilling of the surface. They may possess good constitutions and endure hardships even better than the class just described, but they are furnished with skins of a very poor quality. Their hands chap and become rough with the cold of winter, they shrink from cold bathing because it is unpleasant and because they do not react quickly. Though not specially subject to rheumatic fever, they are very liable to aching of the muscles and fibrous tissues. Under certain cir-

cumstances, which are not easy to define, the slightest draught of cold air upon the skin will cause a prolonged aching in the underlying parts, perhaps in a single muscle, which becomes so painful that it cannot be used, perhaps about some tendon-sheath or bursa which aches and creaks for many days, although there is no disturbance of the general health apparent. This enfeebled condition of the skin is intensified, if not at times produced, by wrong methods of house-warming. Exposure to the hot and excessively dry air of the house in winter in some way, whether by the abstraction of its moisture or by the drying of its oils, renders the skin unable to accommodate itself quickly to the cold of the open air, and this unhealthy condition of the skin becomes gradually permanent.

A person of this class must be cautious about sleeping with the window open. In warm weather he may often do so with impunity, but under certain conditions which he learns to recognize, whether due to the state of his own system or to obscure electrical or thermal changes in the atmosphere, exposure while asleep, to the air from an open window produces very uncomfortable symptoms. The patient wakes with the consciousness that he is chilled and that he cannot move one or more of his limbs for pain. This experience is most likely to occur about daybreak. Sometimes, in winter, the patient may be unable to leave the bed until he has thoroughly warmed and sweated himself under heavy blankets.

It is probable that many of the muscular aches of our female patients are due to exposure to night air during sleep.

PROPOSED THERAPEUTIC USE OF CAVE AIR.

It has long been believed that removal into a suitable atmosphere is the best treatment for chronic diseases of the respiratory organs. Experience has shown that the air of mountains or of the sea is most beneficial, and science has explained that the absence of germ-life in the atmosphere is the chief requisite. At any rate it seems wise in chronic respiratory diseases supposed to be due to or kept up by germs, to seek an atmosphere which is subject to but slight variations in temperature and moisture, and in which micro-organisms do not thrive well. In *Science* May 9th, 1890, a correspondent writes that it has been suggested that the air of a certain great cave in Kentucky be employed for this purpose. The main avenue of this cave is about 2 miles long and 30 feet high, and the whole area of the cave is very great. The floors are dry and covered with dust, metallic substances remain for years untarnished, and the thermometer stands throughout the year at 50°. The cave lies beneath dry sandy regions covered with virgin forest.

It is proposed to erect above the cave a sanitarium for chronic respiratory diseases, and to furnish it with cave air pumped up through large ventilating shafts. It is believed that by this means the sanitarium can be furnished with cool, dry and aseptic air.

Although, as far as is known, the proposal to make a therapeutic use of cave air is quite original, it is known that in various parts of Italy dwellings built near caves have been ventilated by means of air drawn from the caves by wind mills.

In Paris the Palace of the Trocadéro is cooled by the air drawn from great disused stone quarries over which it is built. By means of fans driven by steam-engines about 3 million cubic feet of air are forced into the building each hour, furnishing abundant ventilation for the great auditorium.

Correspondence.

PUERPERAL TETANUS.

Editor Maryland Medical Journal:

DEAR SIR:—Having had, while on a recent visit to Calvert county Maryland, an opportunity afforded me by the kindness of Drs. P. Briscoe and J. T. Dawkins, the attendants, of seeing a case of this formidable and comparatively rare disease, I thought it might interest your readers to hear a short history of this case which is as follows:

Mrs. W., white, æt. 36, multipara, was confined at full term, June 28. The labor lasted ten hours and completed without instrumental aid, was entirely natural, except that the flow after delivery was somewhat excessive, (a feature of all her labors) but it was readily restrained by the attendant.

The mammary secretion having been fully established, and no outward symptom forbidding, she was allowed to sit up on the ninth day (July 7) and it is said, exposed herself to the draught from an open window.

The next day (July 8) some stiffness of the jaws showed itself, interfering with speech and deglutition, and on the following day, trismus was fully developed.

On the 12th of July, I found her with the following symptoms: decubitus natural, rigidity of the muscles of the face and neck, the expression of the face unaltered, unless forcible attempt was made

to open the mouth, when the retraction of the muscles took place, producing the *risus sardonicus*; mind clear, pulse feeble, respiration quiet and easy, skin cool but not moist, abdomen soft and bearing pressure without pain. She admitted, however, that at times she had pain at the *epigastrium running through to her back*; lochia very offensive, semi-fluid and of a dirty muddy hue.

On the night of the day of my visit, she became very restless, and desired to be moved in bed, but before any assistance could be given her, she attempted to raise herself, bringing on by the effort a general tetanic convulsion, ending in fatal asphyxia in about five seconds. This was the second day of the disease and the twelfth of her confinement.

The treatment pursued was antiseptic irrigations to the vagina and womb, hypodermics of morphia, 1-6 of a grain, as often as her sleeplessness required it, and rectal alimentation. A singular feature of her case was that a year or more before, she had witnessed the death of a horse on the farm by lockjaw, and from that date expressed her conviction that she would die by the same disease.

In a disease the pathology and etiology of which are confessedly so obscure, it is presumptuous perhaps, to hazard an opinion, but might not the decomposition of a uterine clot have been in this case the predisposing, and the influence of a draught, the exciting causes of the attack?

Respectfully,

J. R. QUINAN, M. D.

TOMATO SORE MOUTH AND THROAT.

Cambridge, Md., August 26th, 1890.

Editor Maryland Medical Journal:

DEAR SIR:—In your issue of the 23rd, instant, Dr. William T. Catheell makes a

a request of his professional brothers that if any one of them had seen a case of "Tomato Sore Mouth and Throat," he would deem it a favor to report it, and having had several cases of the kind I with pleasure comply with the request.

I have also heard of similar cases occurring and treated by physicians in this district.

The worst case I ever saw was in the wife of an Episcopal minister of this country who was passionately fond of tomatoes, cooked or raw, and would persist in eating them, notwithstanding after every indulgence she would suffer more or less from inflammation and irritability of the mouth and fauces which the use of simple domestic washes and gargles would relieve, but this attack was attended with so much inflammation and irritability of the mouth and fauces with difficult and painful deglutition, tongue and lips very red and swollen, a scarlet efflorescence on different parts of the body so alarmed her as to cause my being called to see her. In the course of three or four days, treatment with fractional doses of calomel combined with 5 grs. of bicarbonate of soda given every three or four hours with soothing deinulcent washes and gargles for the mouth and throat, and crushed ice "ad libitum," she was all right again, and from that day to this (4 or 5 years ago) she has enjoyed perfect health, and has never eaten tomatoes since, bearing in mind the good old aphorism, "tolle causam cessit effectum."

A lady relation of mine with the same "tomato idiosyncrasy" can freely indulge herself in eating them with perfect impunity provided they are well sweetened with sugar.

ALEX. H. BAYLY, M. D.

Drs. H. H. Biedler, W. Osler and H. P. C. Wilson are in the list of those at the meeting of the British Medical Association this year.

Dr. LYDSTON'S REPRINTS.

Opera House Block, Chicago,
August, 25th, 1890.

Editor Maryland Medical Journal:

DEAR SIR:—As I have received many inquiries regarding my lecture on "Sexual Perversion" announced in your valuable JOURNAL, please announce that I shall be pleased to send a copy to any physician who will enclose stamp for same.

Yours etc.,
G. FRANK LYDSTON, M. D.

Miscellany.

SYPHILIS HEREDITARIA TARDA.

Heinrich Neu understands by *syphilis hereditaria tarda* all syphilitic phenomena which have their origin in hereditary infection and appear at a more or less advanced age. He, however, does not deny the possibility that in single cases hereditary syphilis may remain latent for a long time, perpaps until puberty, and and only then present severe specific phenomena. As a proof that in such cases heredity, and not syphilis which has been acquired during the first few years of life, was in question, the author considers the grave and general disturbances of nutrition and development which present themselves in such patients, and which are never offered to such a degree by acquired syphilis. The grayish-white color of their complexion and their earth-colored, leather-like skin he also considers a proof of hereditary syphilis.

In regard to the diseases of the bones, the frequently observed solution of continuity between diaphysis and epiphysis (so-called pseudo-paralysis), as well as the equal thickening of the anterior border of both tibiae and the increased transverse diameter of the skull, are to be regarded

as characteristic of hereditary syphilis. On the other hand, neither the affections of the joints nor those of the skin or mucous membranes offer anything which could be differentiated from acquired syphilis. Again, the three abnormalities set forth by Hutchinson—*i. e.*, certain diseases of the eye, ear, and teeth—are pathognomonic of hereditary syphilis. As regards the eye, keratitis interstitialis profunda is nearly always the result of hereditary syphilis. Disturbances of hearing may be caused indirectly by suppurative processes in the naso-pharynx and Eustachian tubes, or directly by a purulent otitis media, and finally they may also consist in a suddenly appearing deafness without any prodromal phenomena. The development of the teeth is inhibited and their structure changed.

At the end of his work the author quotes seven cases of grave tertiary syphilitic affections occurring in middle-aged persons, the histories of which do not mention any specific manifestations shortly after birth or during the first years of life; that in these cases syphilis was in question was proved, besides the objective signs, by the successful therapy; that it was hereditary syphilis was evidenced by the presence of the above-described anomalies in the development of the whole body, as well as in that of certain separate organs.—*Journal of Cutaneous and Genito-Urinary Diseases.*

THE EXCESSIVE USE OF COFFEE, AND ITS DELETERIOUS RESULTS.

F. Mendel, ("Berlin. klin. Wochenschrift," 1889. No. 40) maintains that caffeine, even in the form of the customary infusion, when it has been used in excess for some time, is capable of producing a typical clinical picture.

The symptom group which is thus produced is characterized by disturbances of the central nervous system, and by its deleterious effects upon the muscular and circulatory apparatus. In support of these views, the author has noted a feeling of genuine malaise, indisposition for work, despondency, nervous exhaus-

tion, and cerebral neurasthenia.

The action on the muscles manifested itself in a considerable diminution of motor power, which was especially noticeable in movements attended with exertion. There was also tremor affecting the hands. Moreover, the pulse was weak, accelerated, and irregular, and the heart-beat feeble. Sensations of anxiety and cardiac palpitations also occurred.

Disturbances in the alimentary tract were also observed, such as haemorrhoids, obstinate constipation, and nervous dyspepsia.

As the proper plan of treatment, he recommends the complete abstinence from the use of coffee; the avoidance of all excessive exertions; rest and nutritious food.

As a prophylactic measure, excessive indulgence in coffee should be discouraged and its use interdicted in all long-continued diseases accompanied by fever, such as typhoid fever, tuberculosis, chronic pyæmia, in chronic diseases of the brain and spinal cord, in disturbances of the circulation, and in all diseases caused by defective haematoses.—*Journal of Nervous and Mental Disease.*

HYPODERMIC INJECTION FOR DELIRIUM TREMENS.

In *La Semaine Médicale*, July 30, 1890, the following formula is given:

R.—Methylal 75 grains.
Distilled water 5 ounces.

Mix, and use for hypodermic injections.

This mixture is to be injected, hypodermically, in three or four doses during twenty-four hours, and its use continued for four or five days. It produces less evil effects under these circumstances than most of the drugs devoted to the treatment of delirium tremens. Fischer states that these injections are never followed by abscess, and may be employed when an attack of *mania-a-potu* is imminent, as a prophylactic measure.—*Medical News.*

TESTS FOR SUGAR IN URINE.

Dr. Jolles of Vienna has examined more than 600 specimens of suspected saccharine urine by the phenyl hydrazin test proposed by Von Jakob, with the result that it apparently showed the existence of sugar, when other tests showed its absence, in four cases. It is therefore not entirely trustworthy; nevertheless Dr. Jolles considers that it may, in conjunction with other methods, prove of valuable assistance in detecting the presence of small quantities of sugar. The way in which he performs the test is as follows: Six or eight centimeters of urine are put in a test-tube and twice as much hydrochlorate of phenyl hydrazin as will lie on the point of a knife with a somewhat larger quantity of acetate of soda, and the mixture warmed until the salts are dissolved. If this does not occur a little water is added. The test tube is subsequently placed in boiling water for about half an hour and then in a glass of cold water. If there is sugar, a yellow crystalline precipitate of phenylgluconic acid results. As to sensitiveness, in a simple solution of sugar in water 0.024 per cent. can be detected by this means. A solution of saffron forms, according to Crismer, a very sensitive test for sugar in the urine, glucose having the power of decolorising such solutions completely even when present in very minute quantity. The test is performed as follows: Two cubic centimetres of liquor potassæ are mixed with one cubic centimetre of the urine to be examined, and the mixture added to five cubic centimetres of a solution of saffron of the strength of 1 to 1000. Decolouration shows that sugar is present. Sometimes normal urine contains sufficient sugar to produce this effect. At least three times as much saffron as urine must be used. The less of the former in proportion to the latter, the more delicate the test. It would appear that this reaction might easily be made the basis of a very simple quantitative test for sugar in the urine, which would require no boiling, and where there

would be none of the difficulties or uncertain ties which accompany the present processes for that purpose.—*Lancet*.

“NERVE NÆVUS.”

The *Medizinische-Chirurgische Rundschau*, in reporting on a case of “nerve nævus” which had been communicated by Dr. Unna to the Medical Association at Hamburg, mentions that so far only three cases of this rare affection had been described, and that it had been named by some Ichthyosis linearis neuropathica. The disease is marked by peculiar streaks, which, starting from the superior portion of the glutei and proceeding across the bend of the knee to the inner surface of the tendo Achillis, extend along the dorsum of the foot up to the small toe. These streaks consist in the upper portion of flat papules, partly covered with scales, but lower down they gradually present a more uniformly raised and indurated appearance. In the case presented by Dr. Unna the affection had appeared in the second year of the child’s life, and remained almost unaltered. He rejects the hypothesis of any connexion of this disease with the peripheral cutaneous nerves which is advanced by previous authors, because it follows an entirely different course to that taken by the nerves. He considers it more probable that the so-called “lines of fissure” observable in the embryo offer a hint of the true explanation.—*Lancet*.

TESTS FOR ARSENIC IN WALL-PAPER.

The British Medical Journal describes the following simple tests for arsenic in wall-papers: Turn down an ordinary gas-jet until the flame is wholly blue. Then a strip of the suspected paper, about one-sixteenth of an inch wide, is brought in contact with the outer edge of the flame. If arsenic is present, a gray coloration will be seen in the flame, and, if the paper is burned a little more, a garlic-like odor can be detected in the fumes. If, on removing the paper from the flame, the charred portion is of a

reddish color, copper is present (arsenic used for this purpose is usually in the form of arsenite of copper). On again placing the charred paper in the flame a green coloration, due to the copper, is seen.—*The Sanitarian*, July, 1890.

THUNDER AND SOUR MILK.

The effect of thunderstorms in turning milk sour is a matter of constant observation in every household. It is not certainly known to what element in the air this souring action on milk is to be directly attributed, and most people are content to ascribe it to "electricity in the air." An Italian *savant*, Professor G. Tolomei, has lately made some experiments with the view of elucidating this question. He found that the passage of an electric current through the milk not only did not hasten, but actually delayed acidulation, milk so treated not becoming sour until from the sixth to the ninth day, whereas milk not so electrified became markedly acid on the third day. When, however, the surface of a quantity of milk was brought close under the two balls of a Holtz machine the milk soon became sour, and this effect he attributes to the ozone generated, for when the discharge was silent the milk soured with greater rapidity than when the discharge was explosive, in the former case more ozone being formed than in the latter. The souring of milk is generally attributed to the growth of a ferment (*bacterium*), which converts the milk sugar into lactic acid. It is possible, then, that the presence of ozone in the air overlying the milk hastens the growth and multiplication of the bacterium. The first observation—namely, the retardation of souring by the passage of a current through the milk—may be a point of practical importance to milk traders. Any methods of preserving milk from its first retrogressive changes, which does not involve the addition of extraneous substances (antiseptics) to the milk, and which is at the same time cheap, effective, and not likely to prove injurious to the consumer, is sure to be

welcomed at a time when milk is to be sent long distances to market, and is often stored for a considerable time before it reaches the consumer.—*British Medical Journal*.

RESECTION OF THE LIVER.

At a recent meeting of the Academy of Medicine, M. Terrillon recorded the case of a woman, aged fifty-three, who was admitted under his care at the Salpêtrière suffering from a painful and voluminous swelling in the hepatic region. There was a history of four years' duration. An exploratory puncture was made into the swelling, and a few grammes of fluid resembling that of hydatid cysts drawn off. As, however, the tumor diminished little or nothing after the puncture, laparotomy was performed on April 1st, the abdomen being opened by an incision running parallel with the false ribs of the right side. A portion of the liver about the size of two fists was drawn outside, and was found to be riddled with innumerable small hydatid cysts. Some of them were already empty, but as the tumor had hardly at all diminished in size, and was continuous by means of a broad base with the liver substance, it was resolved to resect it. As, however, a formidable haemorrhage was to be feared, an elastic band was placed round the base of the growth, and thus an artificial pedicle was constituted. The tumor so held by the elastic ligature was in this way separated from the body organ and fixed outside the abdominal cavity. Seven days were then allowed to elapse to give time for the usual adhesions to organise and shut out the peritoneal cavity. At the end of this time the now gangrenous swelling was removed, together with the ligature. The floor of the existing wound was of course formed by sphacelated hepatic tissue, but securely shut off from the peritoneal cavity by the adhesions which formed. Within six weeks the wound had completely cicatrised over, and now the patient, whom long suffering had reduced to a skeleton, was regaining

ing her usual strength and weight, and leading her ordinary life.—*Lancet*.

VALUE OF THE DIAZO REACTION.

Dr. L. Rütimeyer, who has made between two and three thousand trials of the so-called diazo reaction of urine from 260 patients, declares his belief that it is a very useful guide both in diagnosis and prognosis, being especially valuable in phthisis and typhoid fever. In phthisis he regards it as denoting absorption of caseous matter, and when it is persistent as implying rapid mischief and an early and fatal termination. In cases of general miliary tuberculosis it was always obtained. The number of typhoid cases which were examined was 1,130, of which 87 were fatal. The presence of the reaction is very constant, and it can generally be obtained early. It does not seem to be present in pyrexial intestinal catarrh. If the reaction is not obtained during the first or second week, the case, if one of typhoid at all, must be a very slight one. It cannot, however, be affirmed that a well-marked and constant diazo reaction is any sign of a fatal termination, as with phthisis. The reaction is never given by the urine of healthy persons, and was not observed in hysteria, myelitis, hepatitis, diabetes, cystitis, pyelonephritis, benign ovarian cysts, cholelithiasis with jaundice, gastro-abdominal catarrh with fever, or in a number of surgical diseases. It was occasionally present in cancer of the stomach and oesophagus, chronic nephritis, caries of bone, cold abscesses, pyæmia, scarlatina, pleurisy with serous effusion, tubercular meningitis, and heart diseases. It was more frequently obtained in croupous pneumonia, actinomycosis of the lung, and malignant diseases of the peritoneum. The method of testing is very simple, two special solutions only being required, a concentrated solution of sulphanilic acid in water and a solution of nitrite of sodium of the strength of 1 in 200. The actual test solution is prepared immediately before use by mixing 200 parts of the sulphanilic acid solu-

tion with 10 of pure hydrochloric acid and 6 of the nitrite of sodium solution. This mixture is added to an equal volume of the urine, and sufficient ammonia added to render the whole alkaline. A bright or carmine red coloration denotes the diazo reaction. After from twelve to thirty-six hours a deposit occurs, the upper part of which is green or black.—*Lancet*.

THE PROTEIDS IN THE URINE IN VARIOUS FORMS OF ALBUMINURIA.

Dr. D. Noel Patton, Mr. John Douglas, and Mr. Ronald Mackenzie publish in the *British Medical Journal* the results of numerous observations on albuminuria in acute and chronic parenchymatous nephritis, in amyloid disease of the kidney, and in heart disease, on functional albuminuria. They consider that Senator was right in the conclusion that, in all cases of albuminuria, both serum-albumin and serum-globulin are present, though their proportions vary within wide limits, the quotient of the amount of serum-albumin divided by the amount of serum-globulin being sometimes as low as 0.6 and sometimes as high even as 39. The quotient is high in acute nephritis when blood is absent, though globulin is in excess when haemoglobin is present; the quotient sinks as low as 0.6 when the disease becomes chronic, the alteration depending on the condition of the patient. Amyloid disease can not be distinguished from the ordinary forms of chronic nephritis by the high proportion of serum-globulin, as maintained by Senator; and functional albuminuria is not characterized by the high proportion of serum-globulin, as suggested by Maguire. The proportion of the proteids to one another varies much in the course of the day, serum-globulin being always highest during the night and reaching its lowest point after breakfast, the amount of proteids passed bearing a tolerably direct proportion to the amount of the proteids taken, though a milk diet increases the proportion of serum-albumin. Ap-

parently, high arterial pressure favors the transudation of serum-albumin, while a low pressure increases the proportion of globulin transuded.—*New York Medical Journal.*

NEW TREATMENT OF TUBERCULOSIS BY THE VACCINE METHOD.

On November 19th, last, Drs. J. Grancher and St Martin addressed to the *Académie de Médecine* a sealed packet relating to a method of treatment and preventive inoculation of tuberculosis based upon numerous experiments which they had made on rabbits. The communication made by Dr. Koch to the Berlin Congress (of which the full text was published in the *British Medical Journal* of August 16th), concerning the results which he has obtained in rendering guinea-pigs refractory to tuberculosis, or in curing them of advanced forms of tuberculosis, has induced MM. Grancher and Martin to make known their researches on the same subject earlier than they would otherwise have done. In all these experiments they chose the rabbit as the subject of inoculation and intravenous injection, because there is thus produced a tuberculosis which kills very quickly, and at an almost fixed date, with constant lesions of the liver, the spleen, and the lungs, and which defies all local treatment. Tuberculosis thus induced being always fatal, a solid basis is thus secured which allows exact appreciation of the negative or positive results of any method which tends to produce the refractory state or to cure after infection. The method employed by MM. Grancher and St. Martin was the injection of tuberculous cultures attenuated in various degrees, and used like the dried spinal marrow in Pasteur's treatment of rabies and hydrophobia. Nine degrees of attenuation have been obtained, the four last being such that the cultivations remained sterile. The injections were made first with the most attenuated cultivations, and then with more and more virulent ones. The authors consider that by this method they

have succeeded, on the one hand, in conferring on rabbits prolonged resisting power against the most certain and most rapid experimental tuberculosis, and, on the other hand, in conferring an immunity against that disease, the duration of which remains to be determined.—*British Medical Journal.*

Medical Items.

Professor Braun of Jena has been offered the chair of Surgery at Königsberg.

The first Italian Paediatric Congress will be held at Rome about the middle of October.

Since 1866 the University of France has conferred the degree of M. D. on thirty-five women.

The sixty-third Congress of the Society of German Naturalist and Physicians will be held at Bremen, September 15th to 20th.

Virchow is not satisfied with the crowded condition of the Pathological Institute at Berlin, and is endeavoring to have a new building erected.

Dr. von Jelenffy, the Hungarian laryngologist, was taken ill at Berlin after the Congress, and died of heart disease. Professor Neugebauer was detained by illness.

Under the head of "Progress in Medicine," the *Brooklyn Medical Journal* announces with regret that one of its collaborators has severed his connection with that monthly. This piece of facetiousness should be charged to the compositors.

The subject chosen by the Academy of Medicine of Turin for the Riberi prize is "Researches on the Nature and Pro-

phylaxis of the Infectious Diseases of Man." The prize, which is of the value of 18,000 lire (\$3600), is open to international competition.

The next annual meeting of the National Prison Association of the United States will be held in Cincinnati, September 25th to October 1st.

On the recent occasion of the opening of the Emperor and Empress Hospital for Children, at Berlin, Professor Henoch, whose seventieth birthday fell about the same time, contributed 1500 marks (\$375) to it.

It is stated that the Austrian Government will shortly issue an order for the regulation of special medical practice. No medical man is henceforth to be recognized as a specialist in any particular branch of practice who cannot give proof of having specially studied the diseases to the treatment of which he proposes to devote himself.

The French Society of Hygiene will award in 1891 a gold medal of 200 francs, also a silver medal, and two bronze medals, to the authors of the best essays on the following subject: "What is to be done, before the arrival of the doctor, in case of a street accident, or accident in a factory." Further information, 30 Rue du Dragon, Paris.

A sad statement is recorded on the end of the Central Passenger Railway cars of Baltimore. With the idea of assisting travellers, prominent points which these cars pass or approach, are noted on the sides and ends. On one end stands the statement "Greenmount Cemetery and Hopkins Hospital." Should the direction be reversed?

The Eastern Dispensary of New York pays its physicians for daily service \$200 a year, or nearly 33 cents an hour. The Eastern Dispensary is a pioneer institution in medical generosity. This is good but less than a carpenter's wages.

The appointments are made after competitive examinations, and are eagerly contested. There are many "contract doctors" who work for much less than this.

The American Pharmaceutical Association which has just closed its session at Fort Monroe, Va., elected the following officers: President, Alfred B. Taylor, Philadelphia; Vice Presidents, Professor A. B. Stevens, Ann Arbor, Michigan; Charles E. Dohme, Baltimore, and J. M. Goode, St. Louis. Secretary, J. M. Maisch, Philadelphia; Treasurer, S. A. D. Shephard, Boston; Council, P. C. Condidus, Mobile; C. F. Goodman, Omaha; H. M. Whelpley, St. Louis. The Association will meet in New Orleans on the first Monday of next May.

An Army Medical Board will be in session in New York City, New York, during October, 1890, for the examination of candidates for appointment in the Medical Corps of the United States Army, to fill existing vacancies.

Persons desiring to present themselves for examination by the board will make application to the Secretary of War, before October 1, 1890, for the necessary invitation, stating the date and place of birth, the place and State of permanent residence, the fact of American citizenship, the name of the medical college from whence they were graduated, and a record of service in hospital, if any, from the authorities thereof. The application should be accompanied by certificates based on personal knowledge, from at least two physicians of repute, as to professional standing, character, and moral habits. The candidate must be between 21 and 28 years of age, and a graduate from a Regular Medical College as evidence of which his Diploma must be submitted to the board.

Further information regarding the examinations may be obtained by addressing the Surgeon General U. S. Army, Washington, D. C.

J. H. Baxter,
Surgeon General U. S. Army.

MARYLAND MEDICAL JOURNAL.

VOL. XXIII. NO. 21. BALTIMORE, SEPTEMBER 20, 1890.

NO. 495

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CEREBRO-SPINAL MENINGITIS.*

BY W. M. NIHISER, M. D.,
OF KEEDYSVILLE, MD.

About February 20th, J. M. R., a boy, one of twins, 12 years of age was taken sick with rubeola, with the rest of the children, which consisted of his twin brother and another boy older.

The three had a room with fire in it. They seemed to get along quite well, the disease running a mild normal course without having a physician. On the 25th of February this boy was considered nearly well, and on that day had gone from house to the basement for a basket of chips, only a step or two in the open air. The father and mother being away the boys were left in the care of their

older sister. On the night of the 25th, of February the boys retired to their room in their apparent usual health, and, as far as the parents and the rest of boys could tell, all slept as well as usual. The next morning the father went to their room to build a fire, and did not notice anything wrong with any of them, except that he heard one of them give a slight groan; but he paid no attention to it, thinking that they were waking up. When breakfast was ready they were called and all of them came down with the exception of this boy. The father went up and to his surprise found him unconscious, and in a delirious condition, not being able to recognize any of them, or to give an intelligent answer; at the same time muttering, frowning and turning in bed. They sent for me immediately, a mile away. I saw him about 9 o'clock A. M. in the above named condition.

I could get no history of the case as to the condition of his bowels or bladder;

*Read before the Washington County Medical Society at Hagerstown, August 13th, 1890.

in fact there had been no inquiry made, as he seemed as well as the rest.

His temperature and pulse were normal, pupils slightly dilated, and slight opisthotonos. When you would ask him where it hurt him, you could get no intelligent answer. He was moaning and at times would scream out and roll his head from side to side.

I gave him a small hypodermic injection of morphia, which gave him about three hours rest; at the end of which time the symptoms returned.

I repeated the injection of morphia but with less effect than the first time.

At the same time, with difficulty, I gave him a cathartic, also a solution of ergot and quinia. The next day his condition seemed worse, and he suffered very much, crying and screaming so that you could hear him some distance from the house. I then gave him a solution of bromide of potash and morphia, but it did not have much effect. I continued the use of ergot and quinia and on the third day his temperature rose to 102° , pulse 120. I increased the dose of quinia. He was still quite delirious and the opisthotonos more marked; with some enlargement of the thyroid gland on the fourth day. The opisthotonos continued to increase for several days, until his head was thrown back as far as it could be.

At times he would seem to rest for a short while and then go into the wild delirium again. At no time was there any tympanites, or gurgling in the right side. On the seventh day he seemed considerably worse again. His temperature would run up sometimes to 103° but on no time did it run higher than $103\frac{1}{2}^{\circ}$. He lingered along in this condition for twelve weeks, having his relapses of coma and delirium, and at times short intervals of rest.

His delirium was marked on every seventh day. He had the boat-shaped abdomen during his whole illness. He passed his urine involuntarily, and his bowels were kept regulated with enemas and laxatives. He would answer you at

times, and all he would say was, that it hurt him in his head, back and stomach.

I blistered him thoroughly at the back of the neck on the third day; on the fifth day he seemed to rally somewhat and could recognize you, and in reality seemed much better, but in a few hours you knew the worst again.

On the tenth day I blistered him again at the back of the neck and extended it down to the lumbar region; it seemed to relieve him slightly, but nothing was permanent. After the blister healed sufficiently I used dry cups frequently. He was too weak to take any blood from him, being anemic to commence with.

At the close of the fourth week through the suggestion of a brother M. D., I commenced using mistletoe in full doses seeing that the ergot had no influence in contracting the arterioles. It had been recommended to take the place of ergot. Just at that time we were willing for assistance from any source. I changed the solution, to give him rest, to bromide of soda, bromide of potash and morphia, and would give it to him as needed.

I continued the quinia throughout this disease. It was an anxious time for the parents and none the less anxious for me as I was working night and day for the case, with all might and power.

Three other physicians saw the case with me, and expressed themselves that he was one of the thinnest patients they ever saw. He became very much emaciated; in fact, so much so that nothing seemed to be left but the bony skeleton and the skin covering it. You could easily trace the iliac vessels from their bifurcation to their exit from the abdomen.

After he was sick about eight weeks, bed-sores made their appearance over each hip bone and over the sacrum, and they became very deep seated and offensive. He got into a condition then that he could not recognize anything or any one. At his worst he could not raise his hands or feet from the bed, and was unable to move himself in any way. At the end of the twelfth week the relapses of delirium seemed to be farther apart,

and from that time improvement took place, but so slowly, that indeed it was some time before you could notice it. At no time was there any lung trouble. His kidneys seemed to act well throughout his illness. For awhile he was kept up on enemas of milk and eggs, being unable to take anything by the mouth. At times whiskey was administered when he would go into profound collapse. His recovery seemed almost impossible. Just such cases try a physician's skill and patience, and many times you get pretty far down in the valley of despondency.

In Pepper's System of Medicine, Vol. I, p. 818, Stillé says that on every seventh day or multiples of seven, the disease seems to renew its forces, and the patient becomes worse; in this case it was well marked. The delirium, pain in head and back of neck, the boat-shaped abdomen, opisthotonus, enlargement of the thyroid gland and other symptoms were well marked. At no time was there any tenderness along the cervical vertebra; but he was in such a condition of coma nearly all the time even if there had been tenderness in that region, I do not think he would have been sensible of it, or could it have been readily detected. He is now back to his normal condition, few being able to distinguish him from his twin brothers. His recovery was certainly gratifying to me as well as to all interested, and I gave the case time and work sufficient to fully appreciate the recovery, whether it was due to remedies or nature I am not positive.

THE DIAGNOSIS AND TREATMENT OF THE SIMPLER EYE DISEASES.

BY HERBERT HARLAN, A. M., M. D.,
OF BALTIMORE.

Assistant Surgeon Presbyterian Eye, Ear, and Throat
Charity Hospital, etc.

(Continued from page 395.)

Catarrhal or Muco-Purulent Ophthalmia.—In regular gradation this is the

next more severe form of inflammation of the conjunctiva.

It is just between the simple and purulent conjunctivitis. The peculiarity being that there is a secretion or discharge from the mucous membrane. Usually, there is a slight collection of matter at the inner canthus, and on evertting the lower lid, small shreds of mucus are seen on the red and inflamed conjunctiva. This form is distinctly contagious, and beginning in one eye the other is affected by inoculation after a day or two. It often runs through a family, and commonly does so among the children of the poor, who go through their daily face-washing one after another, the same utensil and towel being used for all. There is not much pain or photophobia, and the milder cases run their course and get well in about a week. In the more severe cases where there is much discharge, it is difficult to draw a sharp distinction between a bad case of catarrhal conjunctivitis and a mild one of purulent ophthalmia.

The treatment consists of cleanliness and care to avoid contamination of healthy eyes, and the frequent use of mild astringent or anti-septic eye drops, as solutions of borax grains xii- $\frac{3}{4}$ i, zinc sulphate grain gr.i- $\frac{3}{4}$ i, corrosive sublimate 1-3000. The latter I must confess has not given so good results in my hands as it theoretically should, and as is claimed for it by others.

Purulent Ophthalmia.—Under this head come the cases of inflammation where there is a discharge of pus from the mucous membrane of the eye. The trouble is a very serious one, and is probably the cause of about one-quarter of all the blindness existing in the world to-day. The disease arises always from some direct contamination, and microscopic examination nearly always reveals the presence of gonococci in the discharge. The worst cases are undoubtedly due to gonorrhœal poison. The incubation period is 24 to 48 hours, and the first appearances are those of hyperæmia and inflam-

mation. The lids are red and very much swollen. The eye is painful and there is much photophobia. The discharge varies a good deal in quantity and color. The most common form of the disease is that seen in newly born infants, the ophthalmia neonatorum, and while many eyes are lost in these cases, yet the cornea of children seems to be much more capable of resistance than that of adults, and the profuse discharge sometimes keeps up several weeks, and the cornea still remains clear, though unfortunately this is not usually the case. The danger is from corneal sloughing, due to interference with its nutrition, aided by pressure from the swollen lids and the presence of the retained pus.

Treatment consists first, in frequent cleansing of the eye. In the case of infants, the nurse should be shown how to gently separate the lids and wipe away the pus with pledgets of absorbent cotton. This should be done as often as is necessary to keep the eyes clean, at first, perhaps every half hour. After each cleansing some simple antiseptic but non-irritating solution should be dropped into the eyes, as borax or boric acid grains xii to $\frac{1}{2}$ i. as in this prescription:

Ry.—Sodii Boratis gr. xii
Aq. Camphoræ,
Aquæ aa $\frac{1}{2}$ ss.

M. Sig. A few drops in the eyes after cleansing.

Once, or at most not more than twice daily the physician himself should, after cleansing, instil one or two drops of a solution of nitrate of silver grains v to $\frac{1}{2}$ i. I have reported cases successfully treated with powdered iodoform and also with corrosive sublimate solutions, but I have found the above more satisfactory and when that treatment was begun before the cornea had actually sloughed, I have never seen an eye lost. In the case of adults, the cleansing is best done by frequent injections by the above non-irritating solutions, and great comfort is derived from cold compresses wet with

ice water, and sometimes, when the swelling is very great, scarification of the conjunctiva lessens the tension and greatly reduces the swelling. But here again cleanliness and nitrate of silver grains x to $\frac{1}{2}$ i once or twice a day are chiefly to be depended on. I am certain that much harm results from the too frequent use of nitrate of silver, or from the use of too strong solutions.

Phlyctenular Conjunctivitis. — This trouble, while not strictly confined to childhood, is much more common at that period than during adult life. It appears in the form of one or more little pustules at or near the corneal border. Around each pustule is a small area of injected blood-vessels. After a day or two the pustule breaks and a small superficial ulcer is left. This runs its course and where there are only one or two of the pustules or phlyctens, get, well in two or three weeks without treatment. In the cases where there are many of the phlyctenulæ or where they encroach on the cornea, there is a great deal of photophobia and often obstinate blepharospasm, so much so that in these cases, as in many of keratitis, it is quite common to be told that a patient was blind for varying periods of a few weeks or months. These phlyctenulæ have a very disagreeable way of appearing in successive crops and ill-fed and serofulous children are particularly liable to be affected. The diagnosis is not difficult, provided the little ulcers can be seen, but this is at times not at all easy owing to the pain and blepharospasm produced by exposure to the light. In these cases, it is necessary that the little patient's head be firmly held between the knees of the physician and the lids forcibly but carefully separated with the aid of a retractor. Of course it is well to see the ulcers, but a diagnosis can in most cases be safely made without seeing the eye at all. Let a child be led or carried in with the eyes covered with the hands, the head persistently turned away from the light, the lids red and swollen, cheek broken out in spots from the acid dis-

charge, any attempt at opening the lids being followed by a gush of scalding tears and a violent spasm of the orbicularis muscle, with the history that the little patient cannot stand the light at all during the day, but in the evening plays about and seems quite comfortable, provided there is no discharge of matter, one may be quite sure that has to do with a case of phlyctenular conjunctivitis, and that one or more of the little ulcers is on the cornea. So long as the cornea is not invaded, there is little or no pain, and the eye can be readily inspected.

Treatment.—Lately, in about a dozen cases, I have tried the new antiseptic:

R.—Pyoktanin (yellow) gr. ss.
Aquaæ *ʒ i.*

M. Sig. A drop in the eye t. d.

and while some of the cases seemed benefitted, several were certainly not, and there is no question that this treatment is greatly inferior to this, viz;

R.—Hyd. Oxid. Flav. gr. iv.
Vaseline *ʒ ii.*

M.—Ft. ungt. Sig.—Apply to the inside of the eyelids night and morning, and then rub well with finger on outside of the lids.

It is very important that the salve be carefully made. The dusting of the eye by calomel or finely powdered iodoform is also very efficacious. It is very important, whatever local treatment be employed, that the general physical condition of the patient be improved as much as possible by tonics, good food, cleanliness, fresh air, etc.

(To be continued.)

The Italian government has proposed to France an international scheme of sanitary control for the Suez Canal and the Red Sea. The French journals sit down on the project at once.

ANTIPYRIN AND ANTIFEBRIN.*

BY DR. R. T. HOLDEN,
WASHINGTON, D. C.

At the present stage of the practice of medicine the busy practitioner, owing to lack of time, is willing to take up and use new remedies without sufficient knowledge of them, either as to their chemical composition, or physiological action.

We are guided, altogether, by the manufacturing chemists, and agents of drug houses, and really have little of a scientific value to aid us in the use of drugs.

For several years antipyrin has been on the market. There has been a great deal of discussion as to its value. Eminent medical men have experimented and carefully recorded the results. It has been extensively used in private practice, and hospitals, and yet comparatively few of the physicians who prescribe it, can tell us anything definite of its action, or can regulate with satisfaction the dose to suit the peculiar susceptibility of their patients.

The action of the drug seems to be through the nervous system. This is the conclusion reached after a long series of trials by that eminent practitioner and writer, Dr. William Pepper, who states that "he had seen no effect upon the circulation, upon the respiration, or upon the secretion, save that of the skin."

Dr. H. C. Wood in his paper on "the antipyretic treatment of fever" read before the Association of American Physicians, in 1887, said on this subject:—"With regard to antipyrin, certain experiments made in the University of Pennsylvania seem to give some positive results."

"In the dog, the use of antipyrin diminishes both heat production, and heat dissipation, the former being diminished more than the latter. It is probable that heat production is primari-

*Read before the Clinico-Pathological Society of Washington D. C., March 4th, 1890.

ly affected. The question arises whether this result is due to an effect on the circulation.

He had found that antipyrin had no effect on the circulation. The blood pressure was uninfluenced by its administration.

He therefore concluded that the action of antipyrin upon the bodily heat was entirely independent of any action upon the circulation, and the probabilities are, of course, that it acts through the nervous system. Beyond this our knowledge does not extend."

In my reading on this subject, I have seen nothing more definite or satisfactory written since this opinion of Dr. Wood was expressed in 1887.

Dr. John A. Robison in his paper on "Antipyretic Action of Antipyrin and Thallin," read before the Chicago Medical Society in 1886, says;—"The increase of heat radiation by the dilatation of small blood vessels, and the decrease of oxidation, are the main factors in producing the fall of temperature."

The analgesic action of the drug must certainly take place through the medium of the nervous system. The most marked peculiarity about the drug is its irregularity of action. One patient takes ten grains without any apparent effect, another person is thrown into an alarming condition of collapse by the same dose.

A patient of mine suffering from a severe headache, about the time of the late influenza epidemic, and having read in the daily papers that antipyrin was the sovereign remedy for la grippe, sent to the druggist for three powders of ten grains each, and thinking he would relieve his pain instantly, mixed the three powders together, and took them as one dose.

Beyond sweating freely, and feeling symptoms of vertigo when he assumed the erect posture, he suffered no inconvenience therefrom.

In the case of another patient, a young lady suffering from typhoid fever, the

consulting physician insisted on using antipyrin to reduce an alarmingly high temperature of 105°. He suggested that ten grains be given every two hours until thirty grains had been used, or the temperature had fallen two degrees. Shortly after the administration of the second dose, I was hastily summoned and found my patient almost in extremis.

It required active and continued efforts to revive the young lady, as her temperature remained sub-normal for two hours.

The fact that there was no sign of haemorrhage of the bowels discovered and no symptom except that of unaccountable collapse, with which to deal, left no doubt in my mind that the antipyrin was the cause of the mischief.

Although antipyrin is usually employed as an antipyretic and analgesic, it would be quite tiresome to enumerate the many ailments in which it is said to prove efficacious, and this fact renders it quite necessary to watch the contraindications for its use.

Dr. Huchard, at a recent meeting of the Therapeutical Society of Paris, stated that antipyrin should never be administered when the kidneys are diseased, or in diseases like typhoid fever, in which the kidneys served as emunctories, as it diminished the secretion of urine, and it might be absorbed into the organism with toxic effects.

Extreme debility or weak heart's action is the general contra-indication against its use.

Among the dangerous and unpleasant effects sometimes produced by the drug when given in the ordinary dose are nausea, vomiting, gastro-intestinal disorders, syncope and alarming collapse.

The uncertain and disappointing action of antipyrin led on to the effort to discover a remedy possessing all the good qualities and lacking all that was bad in the drug.

This happy combination was claimed to have been found in antifebrin, and the latter remedy has numbered as many enthusiastic champions as the former.

To cite even extracts from what has been written of the comparative value of these agents, or to give a brief epitome of the conclusions reached by eminent medical men, after long and careful clinical observations, would be to repeat what is well known to all of you, and I will merely give the opinions of a few careful workers on this subject.

Dr. Ademski, in narrating his experience with antifebrin in various febrile diseases, states: "Not all patients bore the remedy well, and in one case of acute rheumatism, a dose of ten grains brought on symptoms of collapse.

The temperature was invariably lowered, sweating was a constant result. The pulse was lowered from ten to thirty beats per minute, and the respirations may be brought down from 26 to 24." (*American Journal Medical Sciences*, March, 1888.)

Dr. J. Solis-Cohen, in *Medical News*, October 9, 1887, says: "The alleged superiority of antifebrin over antipyrin in reducing excessive temperature without injury, led me to employ it during my present term of service in the German Hospital. The few attempts made to reduce high temperature in enteric fever, present it as a much more dangerous agent than I have found antipyrin to be in a very extensive experience with that agent.

So powerful an agent has antifebrin proved in the few cases in which I have used it that, as will be seen, 3 grains, or even 1, will effect very decided results on temperature. The inference is that small doses should be prescribed, say 3 grains, and that the patient should be visited at the end of an hour, and examined as to the reduction of temperature before a second dose is administered, similar precautions being taken as to ordering a third dose; and that when the influence is seen to be marked, subsequent doses should not exceed 1 grain. The dose should not exceed 1 grain; the dose usually recommended has been 8 grains. This has been far too large in my hands."

I remember very well two cases in my

practice that illustrated the danger of the use of antifebrin.

R. R., male, white, aged 33, a powerfully built and strong man, was ill with typhoid fever. The disease ran the usual typical course until the second week, when the temperature began to assume alarming proportions.

One day when I made my evening visit, I found my patient very ill, with a temperature of 105°, and feeling exceedingly anxious about his condition, resolved by the use of an antipyretic to reduce the temperature and secure him some rest.

I ordered eight grains of antifebrin in two doses, and directed the nurse to give one dose immediately, and if the temperature had not fallen two degrees in two hours, to administer the second dose.

I was summoned at midnight to see the patient, being told that he was dying, and found him in apparent collapse; his skin was bathed in cold perspiration, his lips and finger-tips cyanosed, his pulse about 150, and temperature subnormal.

By hypodermic injections of brandy, the application of heat and friction to the body, and other restoratives, he rallied in about an hour.

The nurse stated that after giving the first powder a slight reduction of temperature took place, but not enough to cause the patient any feeling of relief, so at the end of two hours she gave him powder number two, and in half an hour the symptoms of collapse appeared.

The second case was that of L. L., white, aged 10 years, the son of a druggist. The boy was suffering with cerebral meningitis, had a temperature of 105°, and was having convulsions every half hour.

I resolved to reduce his temperature as speedily as possible, and with this end in view gave him five grains of antifebrin in two powders; the second powder to be given two hours after the first, if no reduction of temperature took place.

His father sent for me in great haste

in an hour after he administered the first powder.

The temperature of the patient was sub-normal, and all the symptoms of extreme collapse presented themselves. By rapid action he was revived, and finally recovered from the illness, and it is almost needless to state, the second powder was not used.

These few cases may serve to illustrate the remarkable uncertain action of antipyrine and account for lack of faith in the value of the drug.

The great amount of testimony that we find in the medical literature of to-day relative to the good and bad effects of these remedies, the superiority of one over the other, and finally the uselessness of both, is really sufficient to make most of us extremely skeptical on the subject.

The different statements have the support of men eminent in the profession, who insist on the correctness of their views, because of careful and extensive clinical observation.

I have formed the following conclusions on this subject:—

1st, Antipyrin is a valuable remedy, but needs to be used with great caution, and ought never to be administered except by direction of a physician.

2nd, Its most successful and satisfactory use is as an antipyretic, and although largely used as an anodyne its action is too variable and uncertain to permit of our substituting it for so true and tried a drug as opium and its alkaloid morphia, except in cases where the use of the latter might be contraindicated.

3rd, My experience with antipyrin leads me to believe that it varies in strength and purity, and consequently must vary in action in a given dose.

4th, Individual susceptibility also effects, in a remarkable degree, the action of the drug, and I think is more to be considered in connection with its use, than in prescribing morphia, and certainly as much as when using chloral.

5th, The good effects of antipyrin have been much overrated, and its action is often imaginative.

This would seem to be the case when it is used, and highly recommended by a celebrated German physician to relieve the pains of parturition. For this purpose 30 or 35 grains at a dose are injected into the rectum, and this dose is to be repeated a second and third time if necessary.

I have not had sufficient faith in the analgesic properties of the drug to use it in such a manner.

6th, Finally I can see nothing in the medical literature of the day, or in the records of my own limited observation to lead me to regard autifebrin as superior to antipyrin.

It cannot be used in so large a dose, nor is it as safe in a much smaller dose.

If I had to use such remedies, nothing except the absolute impossibility of procuring antipyrin would influence me to use autifebrin.

Society Reports.

MEDICAL AND SURGICAL SOCIETY OF BALTIMORE.

STATED MEETING HELD APRIL 24TH, 1890.

The 710th regular meeting of the Society was called to order with the President, Dr. H. T. Reynolds in the chair.

Dr. A. T. Shertzer exhibited two patients: 1st, white, male, æt. 5, with only a partial use of left arm and some wasting of shoulder muscles. The parents of the child, who were present, stated that about $\frac{1}{2}$ year ago, at table, they noticed that the boy did not use the left arm as usual. He was taken to a doctor, who pronounced it paralysis, and treated it by battery and tonics.

2nd, White, male, æt. 33. Eight months ago left knee began to give him trouble; it became enormously swollen, and he has been under treatment at several hospitals in town. The knee had

been blistered, put up in plaster splints, etc., all to no effect. There is no history of traumatism in the case. Three weeks ago he came under Dr. Shertzer's care. He introduced two issues of eight threads each, one above and one below, into the synovial sac, which were allowed to remain for about two weeks. The swelling is very much reduced and the patient gets about quite comfortably.

Dr. F. C. Bressler said the case of the child is of interest; upon close examination, he was unable to find the head of the humerus separated from the shaft, as stated by Dr. Shertzer. The crepitus occasionally gotten, in the various movements, is the result of some previous inflammation of the synovial membrane. Deformities of a nature similar to this in children and infants are interesting from the many points which cause them. In infancy, fracture of the humerus is very common, as compared to other bones. It occurs chiefly at the upper extremity and is often due to the neglect of the obstetrician in breech presentations to bring the arm down properly when extended above the head. When a fracture has occurred in this way, it may escape attention; usually, however, it is observed that the child fails to move its arm properly; to this may be added some atrophy of the shoulder muscles. This child is five years old, has suffered no injury as far as is known, but while at dinner the father noticed that the child failed to move its arm freely; this was attributed to dentition.

Dentition is accused of many things in infancy, and is a convenient cloak to conceal ignorance. Dentition can be excluded as a factor in this case, as we have atrophy of the deltoid, supra and infra-spinatus muscles. The disease most likely to produce this result are brain, spinal cord, peripheral neuritis and trauma. If due to some brain trouble, it being a monoplegia, it would most likely be a cortical trouble. But we have no evidence pointing to such a condition, such as headache, convulsions, etc.

Again, no signs of tumor or embolism

are pointed out. By these negative signs cerebral disturbance can be excluded. The trouble that gives us most difficulty to differentiate is infantile spinal paralysis. This we all know develops suddenly, and is often characterized by involving certain limited groups of muscles. The history in this case is meagre and vague, and if an acute inflammation had occurred, there were no very marked febrile symptoms, or that an injury had occurred to this child's shoulder during delivery. For want of apparatus to test the child's electrical reaction, absence of febrile history, atrophy, chiefly of deltoid and the vague and indefinite history in the case, he was inclined to exclude infantile spinal paralysis.

Peripheral neuritis due to diphtheria, he thought, could be excluded by the history and absence of any throat involvement.

Trauma; children of $2\frac{1}{2}$ years, are just about able to maintain their equilibrium, and in their awkward activity, frequently fall. In falling, they may so strike their arms as to cause a separation of the epiphysis from diaphysis or some one may, in suddenly lifting a child, cause the same accident; thus we have enough causes at work to so injure a shoulder as to produce all the symptoms present in this case. He did not think the head could be felt in the glenoid cavity as stated by some. Had there been a separation of the epiphysis, by this time, little or none would have been found, since the head of the humerus is away or distal from the nutrient artery; this would result in the loss of proper nutrition, such being the case, absorption would have taken place, or an inflammation in the joint would have been set up by the head acting as a foreign body and suppuration would have taken place. As to the condition of the bone at present, he thought it might be enlarged from constant friction, an effort on the part of nature to prevent irritation by throwing a cap over the head of the bone. This being a little larger than the bone, gives it the peculiar shape. To sum up, he

thought it primarily a trauma to the arm and shoulder, which may have existed from birth, but not recognized, and the paralysis was secondary, also that the epiphysis was not at present in the joint.

Dr. R. G. Davis said he thought the head of the bone was present, and that it was a case of infantile spinal paralysis. The wasting of the shoulder group of muscles, allowed a lengthening of the ligaments to take place, as the shoulder joint is essentially a muscular joint and not a ligamentous joint, such as the knee, for instance, after the joint is manipulated pretty freely in examining, the crepitus seemed to disappear and he thought this might be accounted for by some previous inflammation of the joints.

Dr. J. B. Saunders said he was interested in the case, because $2\frac{1}{2}$ years ago he had treated the child at the City hospital dispensary. The mother at that time said that the child was restless for 2 or 3 days previous, and that at the breakfast table she noticed that the child did not use its arm as well as usual. The child had no use of its arm and but little use of its left leg. The patella reflex was absent on the left side and there was a slight wasting of the deltoid muscle. The case was diagnosed as infantile spinal paralysis, and the child was put on tonic treatment with electricity and massage. At the time of the first visit to the hospital the child had fever.

Dr. Shertzer said when he saw the case for the first time (two days before) the mother stated that the child had been treated for the same trouble about six months before it had been taken to the hospital. He had questioned her closely as to whether or not the arm of the child had been brought down at birth of the child, but could get no information on that point. He thought the head of the bone was detached and was present in glenoid cavity.

Dr. David Street said he had a case very similar to this in a gentleman, caused by a neuritis. Had he not heard Dr. Saunderson's statement he would have

supposed it to be a neuritis. He had no doubt it was infantile spinal paralysis. He thought the head of the bone was there and that the ligaments were stretched because of the atrophy of the muscles.

Dr. F. C. Bressler said owing to the vague and indefinite history in the case, it was difficult to arrive at positive conclusions. Taking it all in all the most probable cause for the present condition of the patient was trauma.

As to the second patient of Dr. Shertzer's, he stood in the same relation to it that Dr. Saunders did to the first, case. He (Dr. Bressler) treated the man first. He is a stevedore. About 8 months ago, without any apparent cause, his left knee began to give him trouble. On careful examination there seemed to be an enlarged bursa, with fluid in the synovial sac. Rest, liniments and syr. of iodide of iron internally were prescribed and he was told to go home and to go to bed. He was seen a few weeks after and was no better. The syr. of iodide of iron was discontinued and he was given iodide of potash. He has been through the hospital since then. There is still a little fluid in the joint. He questioned the advisability of putting issues in the knee joint at that period of life. Would it not be a better plan to open the joint and put in a drainage tube?

Dr. R. G. Davis said in cases of this kind you must make up your mind to have a chronic tedious case. He thought the open method would be good treatment in a case of this kind. He had seen many cases of open joint, all with good result. He did not believe that the seton had passed through the synovial sac, for the reason that if it had, it would have, undoubtedly, been followed by suppuration. If it were his case he would treat it by flying blisters.

Dr. Wm. H. Norris said synovitis of the knee-joint is always chronic. It is only in the last decade that we have entered the cavity of the cranium, now we enter it as freely as any other cavity. The same may be said of the liver. Whether

Dr. Shertzer was right to go into the synovial sac with a seton, he would not say, but for him to do so was a step in the progress of medicine. But he did not believe the seton had passed into the joint. He saw a lady some time ago, with an extensive synovitis of both knees, treated with flying blisters with good result.

Dr. Shertzer said he did not think the open method the best treatment, as he had seen a case of the ankle joint treated by the open method which was a chronic case on his hands afterwards.

Dr. Wm. J. Jones read a paper

ON THE USE OF MENTHOL IN SOME FORMS OF DISEASES OF THE NOSE AND THROAT.

Dr. F. C. Bressler said those who desire to use cosmoline or vaseline sprays, will find Davidson's spray No. 59 to be well adapted to those heavy fluids. In 1888 in the Annual of the Universal Medical Sciences, menthol was first described as useful in tubercular, laryngeal ulcers. He would ask *Dr. Jones* if he had used it in any such cases and with what effect?

Dr. Jones said in one case of tubercular laryngitis, the throat was so irritable that cocaine had to be used to allay the irritability before applications could be made, he used the menthol and she comes in every other day and gives a good report of it and says she is more comfortable than before it was used.

J. WM. FUNCK M. D.,
Reporting and Recording Secretary.
1710 West Fayette street.

THE INFLUENCE OF HIP DISEASE UPON THE SHAPE OF THE PELVIS.

Tracou, Pirre; (*Monograph, Bigot Brothers, Lillie, 1890*):—After a careful review of authoritative opinions in regard to the influence of coxalgia upon the shape of the pelvis, and an analysis of the most interesting cases that have been

reported, the author reaches the following conclusions:

Coxalgia, when cured without suppuration during its first or second period, leaves little or no trace upon the conformation of the pelvis.

In its third period coxalgia will have the more influence upon the shape of the pelvis as suppuration shall have lasted longer, and the unhealthy side shall have been less able to bear the weight of the body.

Through the excess of pressure borne by the healthy cotyloid cavity, the narrowing will occur upon the healthy side, the side upon which the coxalgia exists being comparatively larger but not normal.

Coxalgia complicated with sacro-coxalgia produces an oval pelvis with sacroiliac synostosis; the excess of pressure may also bring about a union of the iliac bone to the sacrum.

From the standpoint of the shape of the pelvis, the best treatment consists in continuous extension with immobilization, in order to bring about a rectilinear ankylosis. Resection, in cases that can no longer be helped except by operative measures, gives results superior to that of coxalgia that is not treated. Recurrence of coxalgia under the influence of pregnancy are rare.

In most cases delivery will occur spontaneously. The diagnosis, however, must always be made with care, as the narrowing might prove to be considerable and the fetus may present unfavorably, as, for instance, in the narrow part of the strait. An application of the forceps will be needed, if it is possible; failing this, version seems to be indicated. But if the diagnosis have been made early enough, premature delivery is to be preferred.—*American Journal of Obstetrics.*

The fourth annual commencement of the American Orthopaedic Association was held in Philadelphia this week.

MARYLAND MEDICAL JOURNAL

Weekly Journal of Medicine and Surgery.

WILLIAM B. CANFIELD, A.M., M.D., Editor

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BALTIMORE, SEPTEMBER 20, 1890.

Editorial.**BLUE URINE.**

In addition to the variations in the intensity of the normal coloring-matter of the urine, certain startling changes are at times observed.

After the ingestion of carbolic acid or creasote, or the application of tar ointment to the skin, the urine may become *dark* or almost *black*. A similar color is seen after protracted intermittent fever; also in bilious attacks, and as the result of haemorrhages; also in patients suffering from melanotic cancer.

Rhubarb colors the urine a deep *yellow*

which, in the presence of ammonia, turns to *red*. Santonin imparts a striking *orange-red* color to alkaline and a golden *yellow* to acid urine. The use of infusions of senna and logwood give a *reddish* tinge. A *dusky* hue is observed during the use of gallic acid. In cases of jaundice the urine may be of a dirty *green* color from the presence of biliverdin.

A film or deposit of a bright or dark *blue* color is observed in certain specimens of alkaline urine, and is said to be due to the formation of indigo. It may be seen frequently in urine which has partly decomposed, but in fresh urine it occurs chiefly in connection with cholera and typhus. The urate of ammonia precipitated from the highly alkaline urine of cystitis, is occasionally tinted with a beautiful violet-blue.

Sometimes, persons in excellent health pass urine which gives a blue sediment. In the *Trans. London Obstet. Soc.* Vol 3, 1889, Dr. Philips related a case of this sort. The patient, a newly-married woman of 28 years, had been under observation for six years and had, during that time, suffered from three attacks of passage of blue urine. Each attack, as noted by her physician, occurred between the catamenial periods at a time when she was taking no drugs, and to prevent deception, the urine examined was drawn off by the catheter. The trouble began each time with the passage of *greenish-brown* urine, which deposited on cooling, a sediment of the same color. The color gradually deepened and changed, and by the end of a week it was a bright *cobalt-blue*. It then faded through a *greenish-brown* till the normal color was regained. Each attack lasted about a fortnight.

HOW TO EXAMINE FOR LIFE INSURANCE.

Two writers in recent numbers of Medical Journals (C. L. Dodge, M. D., *New York Medical Journal*, and E. R. Palmer, M. D., *New England Medical Monthly*) have been telling the profession how to examine for life insurance.

It is generally supposed that the most difficult part of this undertaking is to get the candidate for insurance, but these writers disclose the difficulties of the subject and explain a few doubtful points. The way of the life insurance examiner is not an easy one. The candidate is either very anxious for insurance, and will conceal the weak points or the agent of the company, anxious for his commission, will endeavor to "help the doctor" by modifying certain statements of the candidate. As a rule the agents of the companies or those in the home office are very ignorant of the duties of an examiner, hence all examinations should be conducted away from the agent.

Few candidates appreciate the question in regard to alcoholic spirits. Their ideas of moderate drinking are very hazy, and the varieties of questions that must be asked before the exact truth is obtained, is at times very tiring to the physician. Another difficulty is to get the pulse at a proper rate. Few men, however phlegmatic, but will have an increased pulse rate while undergoing an examination. Some, with the idea that it is like joining a secret society or lodge are in a state of excitement from the time they enter the office until they leave. Some even try to "brace up" with a drink before being examined, and as a result are rejected, the drinking causing an increased or irregular pulse

rate, and at times albuminuria. Insurance without examination has been suggested in England, but such a policy would be very hazardous.

Care, tact, patience, and a proper weighing of all statements of candidates for insurance will give the best results, and do justice to all interested.

Correspondence.

BIRMINGHAM LETTER.

DEPARTURE FROM THE CONTINENT FOR ENGLAND—MONEY AS AN INTERPRETER—ANNUAL SERMON BEFORE THE BRITISH MEDICAL ASSOCIATION—DR. THOMAS SAVAGE'S HOSPITALITY—DR. PLAYFAIR'S ADDRESS—PAPERS BY DR. AVELING, HART AND OTHERS—TWO LAPARATOMIES BY DR. SAVAGE—PAPER BY DR. BANTOCK AND EDIS—ADJOURNMENT—RETURN HOME.

Birmingham, July 31st, 1890.

Editor Maryland Medical Journal:

DEAR SIR:—I wrote to you last from Munich. I staid as long as I could in Bavaria and Switzerland, giving myself only time to go straight through to London via, Bâsle, Laon. Calais and Dover, so as to reach Birmingham on the 29th. Twenty-four hours ride. I was alone, having parted with my friends in Munich. My struggles with the French language were sometimes almost too much for me, but in the end I was always equal to the situation, for when my tongue and the sign language could not make me understood, a franc always enlightened the intelligence, or loosened the tongue of some Frenchman, who was before absolutely stupid in his knowledge of the English language. I am convinced that every one should be compelled to speak English.

I have much sympathy for a distinguished jurist of my own state, who in his efforts to get some cigars in Paris, entered a shop, behind the counter of which was a French woman. He wanted small cigars. He talked to her and she to him. They made signs at each other. She entirely misunderstood what he wanted.

At last he measured on his finger about three inches, when she threw up her eyes and clasped her hands, exclaiming "Mon Dieu!" It resulted in his getting the largest cigars in the shop, instead of the smallest.

Whenever I am in Europe, it is always with feelings of pleasure that I turn my face towards London. I feel as if I were going home. Always new, always attractive, always something to amuse and instruct. Sooner or later I tire of all other cities, never of London. I rested here a day or two, after so much travel and sightseeing, and reached Birmingham on the morning of the 29th of July in time for the meeting of the British Medical Association.

I staid with Dr. Thomas Savage, Surgeon to Sparkhill Hospital for Women. His son and carriage were at the station to meet me, and I received a hearty welcome from him, his charming wife and hospitable children. Professor Playfair of London, Dr. D. Berry Hart of Edinburgh, and Dr. Austin Lawrence of Bristol, were also guests of Dr. Savage, and a charming set of gentlemen they are. We frequently "threw physic to the dogs," to discuss and appreciate the other good things of life, and crack many a good joke over good cigars, and other unmentionables.

At 4 P. M. I went with Dr. Charles J. Wright, of Leeds, (Vice-President of the Section on Obstetric Medicine and Gynecology) to the Parish Church of St. Martins, to hear His Grace, the Archbishop of Canterbury, preach the annual sermon before the British Medical Association. The sermon was heavy, but the service and music were fine. I saw many familiar faces there; among others Mr. Lawson Tait, who assisted in taking up the collection.

At 6.30 P. M., I went to a very handsome dinner party given by Dr. Savage to 22 prominent obstetricans and gynecologists. He had every thing to refresh and strengthen the physical man, and everything to sharpen and enlighten the intellectual man. I sat opposite to Dr. Savage at the table. Dr. Playfair on his right, and Dr. D. Berry Hart on his left. Dr. Bantock on my right, and Dr. Edis on my left. Drs. Aveling, of London, Barbour of Edinburgh, Smyly of Dublin, (Head Master of the Rotunda Hospital), Wright of Leeds, Cullingworth of St Thomas' Hospital, London, and Lawrence of Bristol, were of the company.

At 9 P. M. we went to hear Dr. W. F. Wade (President of the Association) deliver his address.

At 10 o'clock the next morning the sections met. Dr. Thomas Savage (President of the Section on Obstetric Medicine and Gynecology), delivered a capital address. This was followed by an able paper from Dr. W. S. Playfair of London, on "Modern Methods of Managing Lingering Labour." It was clear and practical at every point. He told us how his views of 1890 differed from those taught him as a student, thirty-five years ago. He considered what may be done in labour, prolonged in the first stage, by a rigid undilated cervix. The use of opiates, chloral, quinine and mechanical methods of dilating the cervix, were then discussed. He considered chloral the best of all drugs in this condition of things. The modern practice in prolonged second stage was then considered, the two most prominent changes being, the almost entire disuse of oxytocic drugs and the more frequent use of the forceps. The former frequent employment of ergot and its entire prohibition in the chief lying-in hospitals at the present day, was then shown. He then described and approved of abdominal pressure, in prolonged second stage, and closed with the proper use and abuse of the forceps.

Dr. Playfair's paper provoked general discussion, which occupied three-fourths of the morning session, with many per-

sons clamoring to speak, when the president was compelled to cut short the debate. I should like to have spoken on this paper, but so great was the demand of Englishmen to be heard, that I held my peace. I agree fully with Dr. Playfair in every point that he made, and disagreed with many of the speakers who followed him. I wholly disagreed with Dr. Smyly of the Rotunda Hospital, Dublin, with others who advocated the use of opiates, and entirely with the few who use ergot before the termination of the second stage, as I believe there can be no circumstances which require its use before this.

Dr. Aveling next read a paper, "Are Midwives to be Abolished or Bettered," and he ably contended for the latter.

Dr. D. Berry Hart's paper on the "Displacement of the Placenta in Extra-uterine Gestation," was crowded out, by the arrival of the hour of adjournment. He will send me a copy of it when published, and I shall yet have the pleasure of learning something on the subject from this original worker and able teacher.

The section adjourned at two o'clock for lunch, and does not meet again till tomorrow at ten.

At three o'clock I went to see Dr. Thomas Savage do two laparotomies, for the removal of the uterine appendages. He removes them through a very small opening, just large enough to get in two fingers. He has very few instruments by him, uses no antiseptics, but is very clean with every step. Always uses chloroform. Nearly always inserts a drainage tube. He is blessed with a capital assistant in his son, who is now studying medicine. I never say a better. When the operations were over, I said to him that if these had been my cases I would not have used drainage tubes in either, and asked him why he did, as there was no escape of blood into the peritoneal cavity, and no bleeding from any point. He replied, "that he always felt safer when he had in a drainage tube." He, like others of whom I have

spoken in these letters, does not believe that the presence of many persons compromises the operation. About fifteen persons were present at these operations. (Dr. Bantock was one of them.)

Dr. Savage is a charming man, always ready to pleasantly answer questions and communicate his knowledge, and takes those present at an operation to see his patients from day to day afterwards. No man gets better results.

One custom he has at his hospital which I liked much, and which I shall adopt at the Hospital for the Women of Maryland, and that is, he has a good cup of tea served to himself, his assistants and guests at between four and five o'clock in the afternoon. After one or two operations and the hard work of a couple of hours incident to all practice in the diseases peculiar to women, a cup of good tea goes to the right place, and sets a man up for better and more comfortable work during the remainder of the day.

After these operations, I went with Dr. and Mrs. Savage, Dr. Bantock and Dr. Hart, to a charming garden party at the beautiful country seat of Mr. J. E. Wilson, in the suburbs of Birmingham.

Elegantly dressed ladies, beautiful flowers, charming music by a full band, delicious refreshments in lovely grounds, with a most hospitable host, conspired to make this an occasion long to be remembered.

At 6.30, I went to a dinner party, and at 9.30, I went to a reception given by "His Worship the Mayor of Birmingham in the Council House." Two thousand persons were said to be present. Elegant music, abundant refreshments, crowds of medical men, and numbers of elegantly dressed and charming ladies, in one of the handsomest public buildings in all England, conspired to make this a most notable entertainment. It was given at the personal expense of the Mayor.

On the next morning at 10 o'clock, Dr. G. Granville Bantock of London, read before the Section of Obstetric Med-

icine and Gynecology, a capital paper on the "Importance of Gonorrhœa as a Cause of Pelvic Inflammation." He discussed the opinions with regard to the gonococcus, with the conclusion, that reliance is rather to be placed on rigid clinical observation.

The author himself has not seen a case in which he could obtain certain evidence of gonorrhœa being the cause of salpingitis, ovaritis, etc. He concluded by giving his opinion, that in a few or limited number of cases, gonorrhœa seems capable of producing most serious symptoms, but that these cases are comparatively very rare.

I was called on by the president to speak on this paper, and a long experience led me to substantiate the views of Dr. Bantock. I have seen many cases of gonorrhœa in which no salpingitis, ovaritis, or peri-uterine inflammations resulted, and I have seen no such cases clearly traceable to gonorrhœa. That they may occur I am willing to admit, but as cause and effect, I am sure the number of cases are overestimated.

There was great diversity of opinion in this debate, and the weight of it seemed to be against us. Dr. Cullingworth of St. Thomas' Hospital, Dr. Napier of London, and the President, (Dr. Savage) ably debated the opposite side of the question.

Dr. A. W. Edis of the Chelsea Hospital for Women, London, read a most practical paper on the "Causes and Treatment of Sterility," which elicited much discussion, and in which I took part; but as my views on this subject are so well known in my own country, I will not trouble you with a repetition, only remarking that antiflexion and stenosis of the internal os is, by far, the most common cause, and division of the cervix backward, and the internal os backward and forward, is the most efficient treatment.

Of all the papers read before the Association, I heard none that contained so much original work as that of Dr. Barbour of Edinburgh. He illustrated by

casts taken from a frozen subject, who died just before the termination of the second stage of labor, the conditions of the uterus, vagina, and child, up to that stage, beautifully showing the contracted ring in the lower segment of the uterus, which, no doubt is so often the unappreciated cause of retarded labor, and the seat of what we call "hour glass contraction."

He told me he had been looking all his life for just such a subject, and it is the first time he, or any one else, had obtained one dying at just that stage in labor. I brought home copious drawings from the cadaver.

But this letter has been too "long drawn out." I parted very reluctantly with Dr. Savage and his charming family, and the many friends I had with me, and was off for London on the evening of July 31st. I left Dr. Osler, of the Johns Hopkins Hospital, and Dr. Gordon of Portland, Maine. (with many other Americans) in Birmingham. I had just time, excluding a half holiday on Saturday, Sunday, and bank holiday on Monday (when every thing is closed) to do some shopping, pay bills, and get off to Liverpool on Tuesday, to take my steamer, the City of New York, on the following morning. But I made time to accept the invitation of Dr. Cullingworth of St. Thomas' Hospital, to see him do two laparotomies on Monday. He operates well. He is an able debater, and a whole-soul gentleman.

Faithfully Yours,
H. P. C. WILSON, M. D.

BLUE URINE.

Brooklyn N. Y., Sept. 15th, 1890.

Editor Maryland Medical Journal:

DEAR SIR:—A statement has gone the round of the medical press, to some extent, that tincture of the chloride of iron added to the urine of an opium habitué

will give a blue tint as evidence of morphia. The statement is *not true*.

Yours, etc.,

J. B. MATTISON, M. D.,
Home for Habitues, 314 State St.

Reviews, Books and Pamphlets.

Annual of the Universal Medical Sciences.

A Yearly Report of the Progress of the General Sanitary Sciences throughout the World. Edited by CHARLES E. SARJOUS, M. D., Lecturer on Laryngology and Rhinology in Jefferson Medical College, Philadelphia, etc., and Seventy Associate Editors, assisted by over Two Hundred Corresponding Editors, Collaborators, and Correspondents. Illustrated with Chromo-lithographs, Engravings, and Maps. Vols. I, II, III, IV, and V. Philadelphia and London: F. A. Davis, 1890.

It is hardly possible in these few words to do justice to a work of such magnitude as this. No great change in the model of the work has been made over the edition of 1889, but each section has been carefully brought up to date and a few subjects, such as syphilis, surgical mycoses, and thoracic surgery, have been treated in separate sections. A hasty review of the five volumes seems to show that the work is as good as last year and in places better. The index is of great value, but it is not easy to find the list of authors quoted, as they are not arranged alphabetically in a separate list. The publishers, with their usual enterprise, have spared no expense in the illustrations.

The Throat and Nose and their Diseases.

With One Hundred and Twenty Illustrations in color, and Two Hundred and Thirty-five Engravings, designed and executed by the Author. By LENNOX BROWNE, F. R. C. S. E., Senior Surgeon to the Central London Throat and Ear Hospital, etc. Third

Edition, revised and enlarged. Philadelphia: Lea Brothers & Co., 1890. Pp. xxii-716. Price, \$6.50.

In bringing out a third edition of this book, the author has slightly altered the original title, and has more fully discussed the intra-nasal and naso-pharyngeal maladies. The tonsils also have received a much larger share of attention than usual. This edition is a great improvement on former ones. The lithographs are fine and the formulæ very convenient. The press work and illustrations are exceptionally well done.

Essentials of Refraction and the Diseases of the Eye. By EDWARD JACKSON, A. M., M. D., *Essentials of Diseases of the Nose and Throat.* By E. BALDWIN GLEASON, S. B., M. D. With 118 Illustrations. Philadelphia: W. B. Saunders. 1890. Pp. 260. Price \$1.50.

These two "cram quizzes" bound in one volume are intended to help the hard worked student over hard places. These are as good as most compends which should always be used as an aid to the memory, and not studied as a text book.

Massotherapy and Massage as a Mode of Treatment. By WILLIAM MURRELL, M. D., F. R. C. P. Fifth Edition. Philadelphia: P. Blakiston, Son & Co. 1890. Pp. 204. Price \$1.50.

This differs little from the last edition which was noticed in these columns a year ago, except the most glaring typographical errors have been corrected, thus making it a well-printed book. The author is to be congratulated on a new edition in so short a time.

Lectures on Massage and Electricity in the Treatment of Disease. By THOMAS STRETCH DOWSE, M. D., Fellow of the College of Physicians of Edinburgh etc., New York: E. B. Treat & Co. 1890. Pp. 379. Price \$2.75.

The most valuable part of this work is the first section, although it is not easy to study such a practical subject as massage from text books. The press work of this publishing house has much improved since the issue of the first numbers of the medical classics.

Miscellany.

HYDROXYLAMINE IN THE THERAPY OF SKIN DISEASES.

1. Groddeck (*Monatshefte für prakt. Dermatol.*, 1890, x, No. 4) has tried hydroxylamine (which was first recommended by Eichhoff) in Professor Schwenninger's clinic. He used it in the form of a salve and in an alcoholic solution, the latter in a strength of 0.075 to 1.5:100. He applied the remedy in the treatment of twelve cases of inveterate psoriasis, four cases of scabies, two cases of mycosis circinata (pityriasis rosea), and in one case of each of the following affections; pityriasis versicolor, lupus erythematodes, pityriasis rubra, eczema seborrhoicum, and seborrhœa capitis. A favorable effect of the action of the remedy was only seen in eight cases of psoriasis, but which also appeared more slowly than that which was observed after the employment of chrysarobin or pyrogallic acid. Upon the *healthy* skin hydroxylamine, in a dilution of 1 to 1,000, had no influence. A 0.2-to-0.5-per cent. preparation causes occasionally phenomena of irritation, while a one-per-cent. preparation nearly always excites such. The remedy seems, according to the author, not to be appropriate for patients who are not confined to bed, as it requires careful watching of the patients, on account of danger of intoxication and its property of easily exciting inflammation.

2. P. J. Eichhoff (*ibid.*) objects to the conclusions of Groddeck that he has employed the above remedy in the treat-

ment of diseases for which it was neither recommended nor appropriate (scabies, lupus erythematodes, and pityriasis rubra). Besides, the manner of application was not adapted to the purpose, and the strength, especially of the salves, which always act less powerfully than solutions, insufficient.—*Centralblatt für die medic. Wissenschaften*, 25, 1890.—*Journal of Cutaneous and Genito-Urinary Diseases*.

ANILINE DYES IN SURGERY.

Professor Garré and Dr. Troje of Tübingen have recently published an account of their researches on the new aniline dye antiseptic, pyoctanin, from which it would appear that this substance is hardly to be credited with all the wonderful power ascribed to it by Professor Stilling. They find that so far from being extremely diffusible, it does not seem able to gain an entrance into tissues that are at all indurated. Thus in a case where large quantities of a $\frac{1}{2}$ per cent. solution had been injected into the cavity of an abscess of the thigh, it was found post mortem that the walls of the cavity were not even stained. Whitlows and other suppurating sores of the hand were dressed, after having been opened, with pyoctanin, but though there were no undesirable effects there was certainly no more rapid cure than there is in similar cases when more ordinary treatment is adopted. Dr. Troje remarks that there is plenty of evidence in literature that many kinds of bacteria are not destroyed by aniline staining. For example, Cornil and Babes recommended that methyl violet should be used for staining living bacteria. Baumgarten recommends vesuvin, and Birch-Hirschfeld fuchsin and methyl blue for the bacilli of malignant pustule. Again, according to numerous authors, colouring nutrient culture media with various aniline colours does not prevent bacteria from multiplying in them. Experiments made with pus cocci showed that a solution of methyl violet of the strength of 1

in 1000 does not destroy them even in twelve hours. It therefore seems to Dr. Troje that the name pyoctanin is not deserved. Dr. Fessler, of the Munich clinic, has obtained better results than the Tübingen observers. He employed "superfine" methyl violet from a dye shop, which he used in a solution of the strengths of 1 in 10,000 to 1 in 1000 for washing wounds and sores, and for impregnating cotton and gauze dressings. He found that a cure was effected very rapidly, the results being especially good in the case of contused deep wounds with discoloured edges. The only objection he sees to the use of this substance in practice is its powerful staining qualities.

—*Lancet.*

TREATMENT OF ACNE.

In the *Revue Thérapeutique Médico-Chirurgicale*, Isaacs recommends the following for acne:

R.—Camphor }
 Vaseline } of each 150 grs.
 Beta-naphthol }
 Precipitated sulphur 1½ ounces.
 Green soap ½ ounce.

—M.

Apply to the affected part for from three to fifteen minutes, according to its susceptibility. After using this lotion, use in its place, after thoroughly drying the skin:

R.—Resorcin } of each . . .
 Salicylic acid 7 to 15 grains.
 Oxide of zinc 30 grains.
 Vaseline 6 drachms.

—M.

This is to be allowed to remain on all night, or a less time if it is too stimulating, and is itself to be followed by an emollient, such as cold cream or chalk powder.—*Med. News.*

ON THE TREATMENT OF CERVICAL CATARRH.

C. H. Stratz, (*Zeitsch. f. Geburts. u. Gynäk.*, xviii., 2).—In order to deter-

mine the therapeutic effects of the chloride of zinc, the author made a series of tests with this substance in a large number of cases. Bröse and others attributed a peculiar specific action to the drug in cervical and uterine catarrh. The author was surprised that Bröse and many others started with the premise that cervical catarrh, erosion, and endometritis always occur together, in opposition to the generally prevalent view of Schröder that it is only in exceptional cases that disease of the cervix progresses to the uterine mucous membrane. In order to test the matter, he excised small portions of the cervical mucous membrane in all suitable cases which were undergoing treatment, and scraped off specimens from the endometrium. Microscopical investigation showed that of 30 cases in which the changes in the cervix were apparent even to the unaided eye, there were but five which were associated with endometritic processes; three times of interstitial, twice principally of glandular form. Even in cases of profuse muco-purulent secretion from the uterine os he found normal endometrium, that is, no distinct proliferation of glandular or connective tissue. He thinks that in the latter cases the vast majority are limited to an isolated disease of the cervical mucous membrane.

He treated a series of 28 cases with daily applications of 10-per-cent solution of zinc chloride, then a second series with application every five days of a 50-per-cent. solution—these two series were compared with two others; a third series of 25 of wedge-like excisions (after Schröder), and a fourth series was treated with concentrated lactic acid. As a result, he makes the following conclusions:

The action of zinc chloride is such as to destroy the less resisting cylindrical epithelium at the surface, but irritates the more vigorous pavement epithelium and the connective tissue stratum to new-formation; it not only does not destroy the deep-seated glandular portion, but by the proliferation of its surrounding elements protects it from further therapeutic action.

It depends upon the resistance of these elements whether, after a longer or shorter period, the imprisoned glandular tissue again begins to proliferate and so lead to relapse.

There can be no thought of a specification of the chloride of zinc or of lactic acid; they are to be regarded only as adjuvants in the cure of milder cases, which properly used, ought never to be harmful, but, on the other hand, do not with absolute certainty lead to cure.

For the radical and certain cure of cervical catarrh, we have as yet no other remedy save the wedge-shape excisions of Schröder.—*American Journal of Obstetrics.*

THE TREATMENT OF PULMONARY PHTHISIS.

Koch's views on the treatment of phthisis pulmonalis have received interesting support from the experience of a chemist, Herr Reuter, made public in April last at a full meeting of the Lower Austrian Industrial Union. Koch, it will be remembered, maintained at the Berlin Congress that among the remedies capable of bringing the malady to a standstill the salts of gold and silver are of the greatest value, and that among them the first place must be given to "cyan-gold." Reuter, who, as director of great *fabriques* of metallic wares at home and abroad, paid particular attention to those in which the articles in question were galvanically gilded or silvered, observed that in the latter industry the *employés* who had consumptive or tubercular symptoms, some indeed who suffered from haemoptysis, found marked relief in their work, and continued to improve so rapidly that in a few weeks their return to health was assured. The favourable impression made on Reuter, as to the curative effects of the gold and silver industry on phthisis, he found confirmed by the testimony of *employés* of every age in these establishments—men, young and old, who had the well-known symptoms of pulmonary consumption, even at an

advanced stage, rapidly getting well as they continued from week to week at work. Further investigations strength-edg'd that impression still more, till he had satisfied himself that for the disease in question a healing virtue resides in the prussic acid generated particularly in those workshops where "cyan-metals" dissolved in "cyan-kalium" are used. Impressed by Koch's views, the Medical Association of Vienna has since bestowed special consideration on Reuter's experiments embodied in the paper read before the Lower Austrian Union last April, and, while admitting the confirmation given to those views by Reuter, it is of opinion that the honour of priority in discovering the efficacy of gold and silver salts in the treatment of phthisis pulmonalis belongs undoubtedly to the latter.—*Lancet.*

THE MICROBE OF GRANULAR OPHTHALMIA.

Dr. Shongolowicz, in a long article published in the *St. Petersburger Medicinische Wochenschrift*, describes a plan of preparing and staining specimens of granular ophthalmia by means of which the true nature of the microbe, which is the cause of this disease, can be made out. This is not, as has been supposed by other observers, a micrococcus, but a short bacillus, from 0.75^u to 2^u in length and 0.3^u to 0.5^u in breadth. It is not easy to stain, gentian violet being on the whole the best stain for the purpose; different segments, too, take very different degrees of stain, and this it is which has given rise to the idea that the microbe is a microcoecus arranged in lines or chains. A number of experiments were made on the eyes of animals, with the result that in two cases an affection was produced which bore considerable resemblance to granular ophthalmia.—*Lancet.*

The Harper Hospital of Detroit issues a bi-monthly, called Harper Hospital Bulletin. It is edited by the Staff.

Medical Items.

Almost all the European travellers have returned to their work.

Dr. Robert Meade Smith of Philadelphia is editor of the *Therapeutic Gazette*, vice Dr. H. C. Wood, resigned.

At the meeting of the American Association of Obstetricians and Gynaecologists in Philadelphia this week, papers were read by Drs. George H. Rohé, J. H. Branham and Wm. S. Gardner of Baltimore.

The *Asheville Medical Record* is the name of a new monthly journal published at Asheville N. C. The editors and publishers are Frank T. Meriwether M. D., H. Longstreet Taylor, A. M., M. D.

The Baltimore *Sun* says that Hinton, the county seat of Summer county W. Va., has a colored woman who claims to be over a hundred years of age. She doesn't look a bit over sixty-five and can "hustle" around over a washtub with most of her younger sisters. Her name is Keziah Annas, and she was born along with another sister and a brother, who are still living, December 10th, 1789. This is perhaps, the first case of such long-lived triplets on record.

The American Gynaecological Society held its fifteenth annual meeting at Buffalo this week. Dr. T. A. Ashby read a paper on "Drainage after Laparotomy" and one on "Laparotomy for Intra-pelvic Pain of Sixteen Years Standing." Dr. H. A. Kelly read papers on "Cephalæmatoma" and "Cancer of the Uterus in the Negress, and Physo-Metro due to Cancer of the Uterus in the Negress." He also showed new instruments. Dr. H. P. C. Wilson of Baltimore, and Dr. Joseph Taber Johnson of Washington were also present.

The *British Medical Journal* says, it

has often been pointed out though the phrase "doctors differ" is so commonly quoted as a reproach to the medical profession, it is one which, both in its origin and its true application, refers at least as much, if not more, to experts in the law, engineering, and in other so-called exact sciences. The Lord Chancellor (Lord Halsbury), speaking at the Mansion House not long ago, went so far as to make it a particular merit of the judges, and one of their claims to the public esteem which they so justly enjoy, "that they spent nearly half their time in differing from their learned brethren."

The Weekly Medical Record says: According to some statistics recently published in France, the annual consumption of salt in England exceeds that of any other country in Europe. For while in France the amount is estimated at about 30 pounds, Italy 20, Russia 18, Austria 16, Prussia 14, Spain 12, Switzerland 8, the Englishman requires no less than 40 pounds. The *Hospital Gazette* thinks that perhaps this is the secret of British thirst. If so, it offers an easy solution to the drink question, which the temperance party should not be slow in adopting.

A committee has just been formed under the designation of a "Committee of Patrons of Foreign Students in Paris." It meets at the Sorbonne, and will undertake the initiation of a propaganda abroad in order to attract foreign students to French schools and universities; thus giving to these on their arrival in Paris all necessary and useful information, as well as a moral support during their studentship; the favouring by every means within its power the development of French education abroad. It is composed of MM. Pasteur (as president); Bontmy, director of the Free School of Political Science; Gréard, rector of the Academy of Paris; Lavis, professor at the Faculty of Letters; Melon-Picot and Sorel of the Institute; and Melchior de Vogüe of the French Academy.

- The Medical Societies will begin work in about two weeks.

A law has recently been passed in England giving the health authorities power to tear down any building which may be deemed injurious to public health, and also to regulate the number of inmates of any house.

During the school year of 1889-90 there were 822 foreign students in the medical school in Paris. Of these 6 were German, 51 English, 7 Austrian, 7 Belgian, 8 Bulgarian, 34 Spanish, 34 Greek, 6 Dutch, 12 Italian, 18 Portuguese, 85 Roumanian, 261 Russian, 20 Servian, 25 Swiss, 71 Turkish, 159 American, 10 Egyptian, and a smaller proportion of Swedish, Persian, and Australian students.

Dr. Henri Huchard published in the *Revue Générale de Clinique et de Thérapeutique* a paper on the reform of medical teaching. French medical teaching, he says, is in its decadence, not because good professors are wanting, but because the system is bad. M. Huchard proposes suppressing the competitive examinations for house-surgeons (*internes*) and dressers (*externes*), who are to be chosen by hospital physicians and surgeons. Lecturers' fees are to be paid by the pupils attending the classes, and not by Government, at a fixed sum. Examiners are to constitute a separate body from teaching professors. M. Huchard also proposes that the posts of hospital physician and surgeon and *agrégé* should be suppressed.

If the committee on the Medical Profession Bill in France is to have its way, foreign diplomas, of whatever country, are likely to be met with slight respect. The committee proposes that no medical man holding a foreign diploma shall be allowed to practice in France unless he has received the degree of Doctor of Medicine from a French faculty, after

having passed the required examinations. In certain cases, however, the Minister of Public Instruction may grant an exemption from some of the examinations. Foreign medical students are to be subjected to the same rules as French students. No person is to be allowed to practise as a dentist unless he has a diploma of doctor, or has obtained a special diploma as dentist, issued by the Government, after examination and a preliminary course of study. Such suggestions give a poor opinion of the progress of truly liberal feeling in France. As they affect England we can only regret them, and hope that they will still not become law. The numerous people of British nationality in France, and the state of our medical education, tend to stamp such proposals as alike harsh and unreasonable.

The Minister of Public Instruction has recently submitted his new Bill on the Practice of Medicine in France to the Parliamentary Committee appointed to consider the question. By this Bill the grade of *Officier de Santé* is abolished. It also provides for the creation of a Board of Examiners, who will travel about to conduct the examinations in the various universities of the Republic. These examiners will not be charged with teaching, and the professors now teaching will cease to examine. As regards English and other foreign doctors, a distinction will henceforth be drawn between those who desire to practise in any part of the dominions of the Republic and those who desire merely to follow the teaching of the French medical schools. The former will, without any exception, have to undergo the same courses of study and pass the whole of the examinations required of a French student before he is allowed to practise. To the latter category will be given certificates setting out that they have followed the lectures or courses; but these certificates will in no case entitle their holders to practise.

MARYLAND MEDICAL JOURNAL.

VOL. XXIII. No. 22. BALTIMORE, SEPTEMBER 27, 1890.

NO. 496

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Original Articles.

A CASE OF ACUTE CEREBRAL MENINGITIS FOLLOWED BY RECOVERY.

BY ALEX. L. HODGDON, M. D.,
OF BALTIMORE.

Some months ago I was called to see T. K., and found him delirious and incapable of recognizing even his best friends. He had violent attacks of vomiting, the vomited matter consisting simply of green mucus. I examined the eyes and found the left pupil dilated and not responding to the stimulus of light; the right pupil, when the light was brought near to it, would dilate and contract alternately. The tongue deviated from the middle line toward the left side. The temperature was about 105° F., and continued elevated for about a week. Upon inquiry I found that some hours

before I was called, he complained of a violent headache, vomited frequently, and had been unconscious for several hours before I saw him. I saw at once that it would be almost impossible for the stomach to retain any medicine, so I ordered an injection of fluid extract of ergot ʒii, which was retained by the rectum. After he had been unconscious for about twenty-four hours and had passed no urine during that time, I thought it advisable to use the catheter, and drew off a great quantity of urine. About this time he became conscious and never lapsed into unconsciousness during the remainder of the attack. He was put on small doses of calomel at frequent intervals and upon ergot and iodide of potassium.

R.—Potass. iodid. 3 i
Ext. ergot. fluid.
Aquaæ āā 3 i.
M., et sig. Teaspoonful in a little water every four hours.

(The fluid extract of ergot used in the prescription was manufactured by Burrough Brothers of this city). He suffered greatly from cephalgia, for which mustard was applied to the temples, but nothing seemed to afford so much relief as leeches to the frontal region. To produce sleep at night, bromide of sodium 3 i was administered at bed-time, and to sustain his strength and afford nourishment, bovinine at frequent intervals and in full doses, also milk. After the lapse of about one week the temperature went rapidly down, and there appeared to be every prospect of a speedy convalescence; but here lies one of the difficult points in the treatment of cerebral meningitis: that is, the treatment of the relapses. The relapse in this case took place almost immediately after convalescence seemed to have begun, and with the relapse came not only the head pains, but also spinal pain which forboded no good and gave reason to fear the rapid involvement of the cord, and the supervention of spinal meningitis. The outlook at this time was far from encouraging. Cerebral meningitis is, in itself, a remarkably fatal disorder, and with prospects of the spinal form becoming engrafted on it, and that, after about a week of severe illness, rendered the prospects for recovery far from flattering, but about the same remedies were used as before the relapse, and the patient steadily improved until at the end of 53 days his recovery was complete. On the 16th day of his illness the dose of the fluid extract of ergot and potassium iodide was reduced to one-half, on the 18th to one-quarter, and on the 22nd to one-eighth the original dose. During the relapse when the temperature was obstinately high, a suppository of quinine, grains xxx was given on two occasions; also, fluid extract of digitalis, gtt. iii every three hours for a short period. Ice was applied to the head during his illness, and his head was kept elevated. No sequelæ resulted from the disease and today he is as well as at any time in his life. The object of the author in writing

this article is to call attention to (what in his opinion) are the great advantages of the fluid extract of ergot over all other remedies in the treatment of cerebral meningitis and all inflammatory conditions of the brain and cord, and it seems to him that nearly every case of acute cerebral meningitis if seen at its onset, could be successfully combatted and brought safely through to a complete recovery, provided that ergot be used in full doses at the very commencement of the attack either by the mouth or (if complete insensibility exists) by the rectum or hypodermatically.

1235 Lafayette Avenue.

CLUB FOOT.*

BY H. L. E. JOHNSON, M. D.,
OF WASHINGTON, D. C.

Mr. President and Gentlemen.—There are few cases in practice which are more annoying to the physician from a treatment point of view, or more distressing to the mother than the congenital deformities of the feet of children. The mother is anxious all through pregnancy concerning the proper formation of her child, and when after birth, it is found to be so deformed, the mental suffering and often anguish is pitiable to witness.

Having met with such a case, what is the duty of the attending physician? Should he wait until several months or years for the performance of the usual operation of tenotomy, or should intermediate steps be taken to correct, if possible, the deformity. The latter would seem to me to be the best, and if no good be accomplished, we have at least done no harm.

I will not refer to the operation first performed by Lorenz in 1784, or to the different manipulations arising since, but will confine my remarks, and obser-

*Read before the Clinico-Pathological Society of Washington D. C., March 18th, 1890.

vations to the treatment other than by operation.

Mr. Barwell opposes the cutting operation in the treatment of talipes on the ground that the disease is always due to paralysis, and that the divided ends of tendon seldom re-unite.

He recommends an apparatus in which elastic cords supplement the paralysed muscles, and counteract those which are contracted. Mr. Ashhurst says that Barwell's theoretical views are in conflict with those views on the subject of club foot by the best authorities. The chief advocate of Mr. Barwell's treatment is Professor Sayre of New York but Ashhurst adds he is too judicious a surgeon to adopt Barwell's method as an exclusive form of treatment.

Professor Sayre's rule for determining whether a tendon should be cut is as follows:

Put the patient under an anæsthetic, and with the feet on the stretch press upon the contracted tendon; if this produces reflex contractions, tenotomy is required.

It occurred to me several years ago, and independent of any theory advanced by others, that the condition might be cured or at least relieved by treatment with splints as in fracture or sprains, for the reason that the bones and ligaments in the new-born are soft and elastic, and I thought I would be greatly influenced by constant pressure, such as might be secured by an immovable splint or bandage, if kept in place for a sufficient period of time. I began to study what sort of dressing would be best, bearing in mind its weight and the discomfort to the child.

A dressing of batting cotton, card board and roller bandage, with starch or paste for keeping all in position, appeared to me to be the best.

Application.—The limb is first wrapped in batting cotton so as to protect it thoroughly from any undue pressure, then a splint made of card board to pass up the foreleg and limb so as also to pass under the foot. This, re-enforced by a

piece to pass under the sole the entire length of the foot where any invasion or evasion of toes is required.

The splints are dressed in the usual way for making it safe and comfortable and should not pass as high as the knee, or be more than one inch in width. The splint should be applied to the side of the fore leg, next to the contracted tendons. The foot is to be brought to the normal position, or rather a little beyond its normal position opposite its deformity. Now, the bandage is to be applied in the usual manner, and sufficiently firm to keep the dressing and feet in the position decided upon.

If, from any cause the dressing should become loose, they are to be removed and reapplied, and should remain in position for from two to three weeks according to the severity of the case. They should be applied on the first day after birth, or as soon afterwards as possible.

I have used the above prescribed dressing in about ten cases of club foot and have secured a permanent cure in all. I will bring my remarks to a close by giving four cases of which I possess full notes, and I may add that in these cases the deformity was well marked.

CASE 1. Baby B., born June 24th, 1885. Healthy and strong, female. Right foot deformed. Talipes varus well marked. Splint applied same day, remained in position three weeks, and when removed, foot found to be normal. She is now living and attending school, and one ankle almost as strong as the other.

CASE 2. Baby F., born December 10th, 1887. Healthy and strong, male. Left foot deformed. Talipes varus. Treated as above. Cured.

CASE 3. Baby B., born February 6th, 1888. Strong and healthy female. Right foot deformed, talipes valgus, left foot talipes varus. Splints applied third day to valgus, fifth day to varus. Valgus was a very bad deformity, varus not so bad. Both cured.

CASE 4. Baby E., born January 10th, 1889. Healthy and strong male. Left

foot deformed. Talipes varus. Bad case. Treated as above. Cured.

The cases presented very hard points, and the prognosis was very unfavorable; but, after removing the splints and subjecting them to the tests of learning to walk, the results are perfect in all. They are all now living and in excellent health.

I think that in the face of these facts that the treatment should be tried in all cases, for as I have stated above, if we do not cure or relieve, we have done no harm, and the treatment is not prejudicial in case of failure to any subsequent attention that may be required.

THE DIAGNOSIS AND TREATMENT OF THE SIMPLER EYE DISEASES.

BY HERBERT HARLAN, A. M., M. D.,
OF BALTIMORE.

Assistant Surgeon Presbyterian Eye, Ear, and Throat
Charity Hospital, etc.

(Continued from page 376.)

Granular Conjunctivitis. — Generally spoken of as granular lids or trachoma. This is a form of conjunctivitis characterized by the presence of small granular bodies on the inner surface of the lids, chiefly in the retro-tarsal fold of the upper lids. There are two forms; the acute, where there is a good deal of catarrhal conjunctivitis, and the chronic having for the most part little discharge. Eversion of the lids is necessary to make a diagnosis, but when this is done there is a little room for mistakes. There has been much discussion as to whether the granulations are hypertrophies of the little villi of the conjunctiva or entirely new formations. The acute forms in favorable cases and with suitable treatment get well in four or five weeks. Chronic trachoma occurring, as is most frequently the case, in strumous people is a most serious affection. The roughened lids producing irritation, then vascularity, and opacities of the cornea with very

serious impairment if not loss of all useful vision. The disease is much more frequent in crowded and ill ventilated quarters and among the poorly nourished and scrofulous. It is contagious and is particularly liable to spread through crowded institutions where many children are thrown together as in houses of refuge and industrial schools, and when there are sore eyes in these places they should be carefully looked after, because in the earlier stages of granular lids the symptoms are not very severe and unless the lids are everted and their inner surfaces inspected, many cases are passed by as "cold in the eyes" until the time for most successful treatment has gone by.

Under the head of TREATMENT special care must be given when possible to general health and surroundings. In institutions, when possible, the patient should be isolated from his fellows, and in all cases special instructions should be given in regard to indiscriminate use of towels and handkerchiefs by the well and the afflicted. In the way of medication, a borax lotion should be used three or four times a day, and the granulations should be daily touched lightly with a smooth crystal of sulphate of copper or with what is probably better, alum; and I have found very great benefit from

B—Tannin

Glycerine

Di

ʒ ss

M.—Sig. a drop in the eyes at bed time.

In the chronic cases where the cornea has become vascular and vision is much impaired and where the conjunctiva is rather dry than moist, jequirity in powder or infusion often does much good, but it sets up a violent inflammation and must be used with caution and the cases carefully watched.

Membranous Conjunctivitis. — This includes the two varieties of croupous and diphtheritic, and as the name implies is characterized by the formation of a false membrane on the palpebral conjunctiva. In the milder form this membrane is

thin and superficial and while the eyes look bad, yet with simple treatment the prognosis is favorable and recovery takes place in two or three weeks. In true diphtheritic cases, however, it is very different. The lids are much swollen and the membrane firmly and deeply attached. Any attempt at separating it leaves bleeding points. The lids have a waxy appearance, the circulation is greatly interfered with and almost invariably the cornea sloughs and blindness ensues. Fortunately diphtheritic conjunctivitis is very seldom met with, and even the croupous form is not very common.

The treatment which I have found most satisfactory is the use of an atropia solution, gr. ii- $\frac{3}{4}$ i, and immediately after dusting the inside of the lids with finely powdered iodoform.

CORNEA.

Inflammation of the cornea can always be seen when photophobia is not sufficient to produce a spasmodic closure of the eye lids.

Foreign Bodies often become embedded in the epithelium of the cornea and are frequently so small as to escape any but a careful inspection. Fortunately, however, the patient feels that there is something in the eye in these cases, and insists on frequent and repeated examinations. Machinists and stone cutters furnish most of the patients of this class. The removal of these particles of iron, emery or stone as the case may be is greatly facilitated by the use of a solution of cocaine. This renders the operation painless to the patient and enables him to direct the eye so as to bring the foreign body into view. When the particles are merely stuck into the outer layers of the epithelium it can be readily wiped off with the corner of a towel, a napkin or with a little cotton twisted tightly about the end of a match or wire applicator. When the particle is deeply embedded in the substance of the cornea proper, a small spud or some other pointed instrument such as the small blade of a pocket knife must be used.

In some cases the greatest care and delicacy is necessary to prevent complete perforation of the cornea. A good light, good eyesight and a steady hand are essential to the operator.

Corneal Ulcers.—These vary very much according to their extent and situation. The superficial ones are much less dangerous than those attacking the deeper layers, and a very small central one which heals readily and leaves only a scarcely perceptible clouding behind interferes much more with vision than quite a large deep seated one which heals and leaves a dense opacity behind if it is situated near the periphery. Then again the deeper the ulcer the more pain and photophobia. Those affecting only the epithelial layer, usually pass away and leave no trace behind, though even those spoken of above under the head of phlyctenular conjunctivitis often show a tendency to penetrate deeply, and when the corneal tissue proper is attacked, there is nearly always more or less persistent opacity of the cornea left. If these opacities are large or central, all useful vision is destroyed. Next to purulent ophthalmia, more eyes are probably lost by corneal ulcerations than from any other one cause. One of the most dangerous forms of corneal ulcer is the serpiginous or crescentic. This starts at the periphery, usually at the upper margin of the cornea and spreading around the edge destroys the nutrition of the central portion and so causes it to slough.

Treatment.—There is no doubt that ulcers on the eye, as elsewhere, should be treated antiseptically. The superficial ones get well most rapidly by the application of yellow oxide of mercury ointment (gr. ii- $\frac{3}{4}$ i) well rubbed in night and morning. Where the ulcer is deep or shows any inclination to spread, the best treatment is without doubt to touch it carefully with the galvano-cautery. This destroys all microbes at once and recovery afterwards is prompt. But a special apparatus is required, and great skill and delicacy is necessary in its use. Next to the actual cautery, but greatly inferior, is

the use of fine point of modified lunar caustic. Whatever form of cauterization may be employed, the after treatment should consist of the frequent irrigation by a corrosive sublimate solution 1-3000. Eserin is also a very valuable remedy provided there is no iritis present. In this case it would of course do much harm. I order

B—Eserin. Sulphat. gr. i
Aq. Dest. ʒ i

M.—Sig. a few drops in the eye every three or four hours.

In cases of glaucoma eserin has been clearly shown to lessen intra-ocular tension. Then it contracts the pupil and shuts out very much of the annoying light. In this way the most troublesome symptom of corneal ulcers, photophobia, is relieved and by lessening the tension the danger from corneal staphyloma very much lessened, and the eye is put in the best condition to get well.

(To be continued.)

TYPHOID FEVER THROUGH THE SENSES.

BY WIRT A. DUVALL, M. D.,
OF BALTIMORE.

It is through the senses that we know our existence. Each has its special part to play in this animal economy, and in man, the special work of fostering his complete happiness. By the sense of smell we are led often to the spot of some hidden crime, or to find something injurious to health and property. By the sense of smell we appreciate that which the sight holds beautiful, (as flowers, etc). Thus I might go on and enumerate almost indefinitely the many "sweets" derived from the senses by other than medical men.

To the medical man the sense of smell is a constant friend, more so than to the business man. This can be verified by a

few careful observations at the bedside of a typhoid patient. In typhoid fever we find a typical odor, not one of decaying matter, not one of improper ventilation, yet an odor perfectly distinct and easy to recollect. It seems to me that one whiff of the odor is sufficient to arouse suspicion. After having received the "whiff" the physician should be as alert as the deer that has just scented danger. This odor seems to grow in intensity as the disease advances, yet does not bear any relation to the severity of the same. It will not be supplanted by one of a more agreeable character. It comes on early and is among the last symptoms to disappear. To give an exact account of this odor is as difficult, it seems, as to tell just how the foetal heart beats. It must be smelled to be appreciated just as the foetal heart *must* be heard before an exact idea of its sound can be made out.

Odors in general are of value from a diagnostic point, and it seems truly so in typhoid fever.

703 Rayner Avenue.

Society Reports.

CLINICAL SOCIETY OF MARYLAND.

STATED MEETING HELD MAY 16TH, 1890.

The 235th meeting of the Clinical Society of Maryland was called to order by the Vice-President, Dr. Wm. H. Norris in the chair.

The following gentlemen were elected members of the Society:—Drs. H. Kepler Gorsuch, Harry Friedenwald, Purnell Sappington, and Conrad Strauss.

Dr. Thomas A. Ashby exhibited a specimen of tumor he had removed from the pelvis of a patient on Monday last. The history of the case was that of pus in the tubes, but at the time of operation no pus was found. The tumor contained blood cells, lymph etc. Prior to the operation the temperature of patient was

101.3°. After it was performed it fell to 98° and has not risen above 100½° since. The general condition of the patient is very much better than before the operation was done. He was of the opinion that the tumor was an ectopic pregnancy, but that fact cannot be determined except by a microscopic examination, which test will be applied.

Dr. Samuel C. Chew read a paper on
FEMORAL PHLEBITIS IN TYPHOID FEVER.

He related the history of three cases of this complication occurring in the course of typhoid fever and said the exact cause of the affection had not been found up to the present time.

Dr. E. R. Walker said that during the late war he had seen two or three such cases, but was not able to add anything from his experience toward clearing up its obscure pathology.

Dr. William Green had seen one case of this affection a good many years ago, but he did not remember much of the detail connected with it.

Dr. J. Edwin Michael said that such a case had been brought into the Maryland University Hospital in January of this year and the patient was said to have had typhoid fever. The leg was greatly swollen and the condition described by Dr. Chew was very evident.

Dr. Samuel C. Chew said he would like to hear from some of the anatomists present an explanation for its more frequent occurrence on the left side. He scarcely believed that the reasons already given to explain it would hardly account for it.

Dr. N. R. Gorter read a report of a successful case of lithotomy on a patient who was taking daily 120 grs., of morphia.

Dr. S. K. Merrick asked if the same specimen of morphia was taken all the time?

Dr. N. R. Gorter replied yes; and the drug was that prepared by Powers and Weightman of Philadelphia.

Dr. John D. Blake read a paper on THE MUTUAL RELATION OF THE HEALTH DEPARTMENT AND THE MEDICAL PROFESSION,

In the paper Dr. Blake discussed the law regulating the duties of the Health Department, particularly of that relating to the Health Commissioner himself. He emphasized the utter impossibility of such a law being carried out. He then spoke of the sanitary inspectors claiming that many times men are appointed to such positions who are totally unqualified to fulfil the duties. He hoped that the medical profession would do all in its power to endeavor to correct such evils and aid the present Health Commissioner in his efforts to bring about such reforms as will elevate the office to the highest standard.

Dr. James McShane said it was a matter of some surprise to him that Dr. Blake had criticised the Health Department so severely. These laws that he quotes are certainly faulty, but the City Council has never made an attempt to remedy them, though repeated efforts have been made in that direction.

Dr. George H. Rohé thanked Dr. Blake for bringing the subject before the medical profession, but there were certain things brought forth in the paper to which he would take exception. If these laws are so faulty as the doctor would have us believe, why did he not present an ordinance when he was a member of the City Council to remedy the matter. He denies that eight out of ten families are as competent as our Sanitary Inspectors.

Dr. John D. Blake said that he did not mean to be personal. He only wanted to present the subject in a way that it had presented itself to him. He was sorry that the Commissioner was not better posted. If he will take the trouble to look over the records of the City Council of which he (Dr. Blake) was a member, he will find that Dr. Blake did report such an ordinance, but the politicians killed it. He wants to arouse the medical profession to do its duty in the matter, and that was why he presented this paper to-night.

W. J. JONES, M., D. Sec'y,
1238 Greenmount Ave.

MARYLAND MEDICAL JOURNAL

Weekly Journal of Medicine and Surgery,

WILLIAM B. CANFIELD, A.M., M.D., Editor

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BALTIMORE, SEPTEMBER 27, 1890.

Editorial.

THE DANGER OF PREMATURE BURIAL.

The chances of being buried alive are so small that it is a wonder that sensible persons ever give it a thought, but it is a fact that those sane on most subjects are very much in the dark in regard to some things which their own senses should clearly perceive. A medical journal in this country claims to have investigated every supposed case of burial alive with the result of finding a false story or a reporter's invention. In England no authenticated cases can be found. In Munich where the dead houses in the

cemeteries are constructed on such elaborate plans that most careful precautions are taken against premature burial, no case can be found where a supposed dead person has come to life. Yet, with what avidity do the old ladies of both sexes seize on to a story of premature burial, and detail it to friends, taking care that their own imaginations do not let the story lose by the telling. So many persons who accept most statements with caution, will accept the physician's dictum on almost any subject without a doubt, and so few persons ever question what their "doctor" tells them, be it ever so wonderful, that the profession should attempt to put these beautiful and child-like confidences to some good by quieting nervous minds on the subject of premature burial. The mere fact that most undertakers inject a fluid (probably containing arsenic) into the aorta should prove to a sensible person that life is incompatible with such a procedure. A physician has many duties to perform towards his patients, and may not one of them be to dissipate false ideas on such subjects as this?

THE PRESCRIPTION OF EXERCISE.

Exercise is rarely specifically and properly prescribed. The physician who prescribed exercise to a letter carrier before he found out his occupation, has probably been more careful since that "break." Dr. Thomas M. Bull (*New York Medical Journal*, August 9, 1890), thinks that we have, in the proper carrying out of exercise, a very valuable and much neglected remedy.

It is used principally:

1. To preserve the health of sedentary people.
2. To reduce deformities.
3. To alter weight.
4. To overcome hereditary and organic disease.

Exercise for the sedentary is invaluable as a cure for those various symptoms of headache, nervousness, helplessness, neuralgia, etc., etc., which so usually accompany a sedentary life, but exercise must be prescribed with caution. The transition to an active life must not be too sudden. Such a change should be gradual to do good, and not too long continued. When exercise is prescribed, the physician should have some acquaintance with the condition of the patient's internal organs. Sudden deaths in athletics occasionally occur through such mistakes, and opprobrium is then brought on legitimate exercise. The proper care after exercise is as important as the exercise itself. Thus it is evident that exercise judiciously prescribed and carefully carried out, may do much good.

Miscellany.

CONDITION OF THE KIDNEYS IN POISONING BY MERCURY.

Some experiments that may prove of interest from a medico-legal as well as from a clinical point of view have been made by a German observer, F. Klemperer, and an abstract of his results is given in the *Centralblatt für Klinische Medicin*, 1890, No. 29. The investigation was made to ascertain the condition of the kidneys in death from poisoning by mercury. The experiments were mostly made on rabbits, and the poison (corrosive sublimate) was introduced into the system by means of hypodermic in-

jections. The mercury was eliminated by the intestines and kidneys. In acute cases, when the amount of mercury was large and death rapid, a considerable amount of congestion was found in the kidneys. If life was prolonged five to ten hours haemorrhages were found in these organs, chiefly in the parenchyma, and there was also cloudy swelling of the epithelium. If the duration of the life was still longer, the parenchyma showed marked signs of inflammation. These were seen to some extent in the tubules of the cortex, but were less obvious there than in the straight tubules; in the latter inflammation quickly led to necrosis. In half the cases there was a deposition of chalk, together with a degenerative parenchymatous inflammation; the former appeared from eighteen to twenty-four hours after death, at first in the casts found in the diseased tubules, and similar deposits occurred later in the straight tubules. Added to the above conditions was generally a slight affection of the glomeruli. When the poisoning became more chronic, the parenchymatous inflammation was less marked. The necrosis of cells in the straight tubules occurred only to a slight extent, and calcification was absent; but in the interstitial tissues the signs of inflammation were abundant. In the kidneys of dogs poisoned by mercury, there was a parenchymatous nephritis, which terminated not in necrosis, but by fatty degeneration of the cells; a deposit of chalk only occurred to a very limited amount. In cases of metallic poisoning the condition of the kidney is very similar in rabbits to that in man, but in the latter fatty degeneration is more common than in the former. The microscopic and macroscopic characters of the kidneys are not so characteristic as to warrant a diagnosis of mercurial poisoning; poisoning by manganese, glycerine, bismuth, all produce much the same appearances, but the deposits of chalk in the inflamed tissues would suggest that mercury was the irritant employed. Prof. Kauffmann ascribed all the changes produced by

mercury to coagulation in the capillaries, producing indirect anaemia, in the wake of which necrosis and calcification followed. Klemperer, on the other hand, was of the opinion that there was no simple necrosis and no definite form of inflammation produced by the action of mercury, but he attributed the results to a proneness on the part of the cells of the kidney of the rabbit to undergo calcification, whilst the same irritant produced in the dog a fatty metamorphosis of those cells.—*Lancet*.

PALATABLE CASTOR-OIL MIXTURE.

In the following preparation of castor oil the disagreeable taste of the oil is—as investigation shows—replaced by a pleasant flavor of almonds.

R.—Castor oil	30 parts
Bitter almonds	2 "
Sugar	30 "
Gum tragacanth	½ "
Orange-flower water	10 "
Water	120 "

Mix.

The only drawback to this mixture is that it requires a good deal of it for a dose, a teaspoonful of the oil being contained in about five teaspoonsful of the mixture.—*Medical and Surgical Reporter*.

FORMULA FOR PULMONARY PHTHISIS.

Gilbert recommends the following:

R.—Creasote	30 to 40 minims.
Arseniate of sodium	½ grain.
Quinine wine	1 pint.

Two small wineglassfuls should be taken directly after each meal.—*Medical News*.

THE GERMICIDAL PROPERTIES OF BLOOD SERUM.

Charrin and Roger confirm the fact first established by Nuttal in 1888, that

the serum from rabbits' blood has a more destructive influence upon anthrax bacteria than that of dogs, although the dog shows greater resistance to anthrax infection than the rabbit. The serum of the latter animal was least adapted as a culture medium for the anthrax bacillus. The morphological changes of the bacilli in the different kinds of serum are also noteworthy, and so constant are their variations of form according to the serum in which they are cultivated, that the authors believe that they can determine from the microscopical examination of the organisms the nature of the serum in which they are growing. Blood serum does not have a germicidal action, but arrests the growth of the bacteria.—*Gazette hebdomad. de médec.—Inter. Journal of Surg.*

KEFIR.

Professor Uffelmann, of Vienna, has made an examination of that preparation of milk called kefir, which has recently been lauded by physicians of Berlin and Paris as well as Vienna for its power of assisting stomach digestion, strengthening the nervous system, and increasing the weight of the body. According to the *Medical Press and Circular*, he finds that the kefir ferment converts the milk into alcohol, carbonic acid, hemi-albumose, and peptone compounds. The casein is broken up into small particles in combination with the fat, forming a kind of emulsion. Uffelmann holds that the lactic acid converts the casein into very fine coagula, and relieves the gastric acid of a great part of its work. The carbonic acid increases peristalsis and the flow of the gastric juice. The peptones and alcohol make the combination better borne and cause it to contribute to nutritive accumulation and assimilation. These are the reasons, he thinks, for the growing repute of kefir as a means to the rapid increase of the weight of the body.—*New York Medical Journal*.

SOME NEW REMEDIES FOR
WHOOPING-COUGH.

Genser was one of the first to apply antipyrin to the treatment of whooping-cough. He gives the results of one hundred and twenty cases; the average duration was twenty-four days, instead of from sixty to ninety, the ordinary term. As many decigrammes ($1\frac{1}{2}$ grains) were administered daily as the child was years old (*Wiener Medizinische Presse*, 1888).

Dubousquet-Laborderie obtained similar results in fifteen cases; there was marked diminution in the frequency and severity of the paroxysms, and the period of decline announced itself much sooner than ordinarily (*Bulletin Général de Thérapie*, t. cxiv. p. 385).

Sonnenberger tried antipyrin in seventy cases of whooping-cough; to young infants he gave it in doses of $\frac{1}{2}$ to $1\frac{1}{2}$ grains three times a day; to older children, from 3 to 15 grains. He also records marked alleviation of the attacks and shortening of the duration of the disease (*Lancet*, March 3, 1888, p. 437).

Antipyrin is, by no means always innocuous when administered to children, and some cases of poisoning have been reported. Rothe, having met with some unfortunate results from antipyrin, made trial of a combination of iodine with carbolic acid, and claims great success from this combination in the treatment of whooping-cough. He says that he has treated hundreds of cases, and cannot remember one in which the affection lasted longer than four weeks. The mixture he employs is as follows:

R.—Acid. carbolic,	gr. xv.
Sp. vin. rect.,	gr. xv.
Tinct. iod.,	gtt. x.
Tinct. belladon.,	gtt. xxx.
Aqua menth. pip.,	$\frac{3}{2}$ ii.
Syrup. opiat.,	gr. cl.

A teaspoonful of this is given to children over two years of age every two hours (*Lancet*, April 6, 1889, p. 701).

Acetanilide (antifebrin) has been used with advantage as a nerve sedative and

antispasmodic in whooping cough. At the meeting of the American Medical Association, held in Newport, R. I., (*Medical Record*, July 6, 1889, p. 21), Dr. Love, of St. Louis, spoke of the treatment of fifty cases of whooping-cough by acetanilide, and regarded it as a valuable remedy; and in a report of cases observed at the New England Hospital during the years 1888 and 1889, Dr. Kate C. Hurd alluded to "the remarkable benefits of acetanilide in pertussis." It "both mitigates the paroxysms and shortens the duration of the disease." The dose is from $\frac{1}{2}$ to 5 grains three times a day, according to the age of the child.

A writer in the *Lancet* asks the question whether phenacetin is a remedy in whooping-cough, and Dr. R. Heimann answers the question affirmatively, having used the drug experimentally in a case in which antipyrin entirely failed. The success was so surprising that he administered phenacetin in two other cases. It reduced the number of paroxysms, which had been from ten to fifteen per diem, to three, and on some days they entirely ceased, only reappearing at night when no phenacetin was given. The dose for a child 3 years of age would be $1\frac{1}{2}$ grains every three hours (*Lancet*, October 19, 1889, p. 811).

Sulphurous acid fumigations have been recently tried in whooping-cough at the Charity Hospital, at the New England and other hospitals. Manby relates, in the *Practitioner* for August, 1888, his experience with sulphurous acid, which has given him great satisfaction. The method is as follows: "The children are in the morning put into clean clothes and removed elsewhere. All their clothes and toys, etc., are brought into their bedroom, and sulphur is burnt upon a few live coals in the middle of the room. The fire is allowed to remain in the room for five hours, and then the windows and doors are thrown open. The child sleeps in the room the same evening. About twenty-five grammes of sulphur to every cubic metre may be burned; this is equiv-

alent to rather more than ten grains per cubic foot. The room is fumigated in like manner during the night, the children practically living in an atmosphere of diluted sulphurous acid gas for some days, while in some cases the process is repeated at the end of the week" (*Medical Record*, August 25, 1888, p. 215).

Weisberger, in the *Bulletin Général de Thérapeutique*, April 15, 1890, speaks enthusiastically of this remedy. He causes to be burned, morning and evening, in the room of the child ten grammes of sulphur, and subjects the child for an hour to the fumes. The gas produced by the combustion of this quantity of sulphur is not sufficiently concentrated to cause more than a slight irritation in the nose and throat.

Recently a new remedy—*ouabaïne*—has come into vogue. In the *Therapeutic Gazette* for June (p. 411) will be found a full summary of all that is known of this new remedy and its uses in whooping-cough. Ouabaïne is, however, a dangerous remedy to give, and as the dose is necessarily very small, great care is needed in its management. Terpine, according to Talamon (*La Médecine Moderne*, July 24, 1890) is a much safer medicament. In children under a year old, according to Manassé, it may be prescribed in the dose of 5 grains three or four times a day. It diminishes the violence and duration of the paroxysms, and hastens the cure of the concomitant bronchitis. Talamon would counsel somewhat smaller doses (10 to 15 grains a day for an adult), though he thinks that large doses may be safely given. He regards the employment of terpine in whooping-cough as "rational." It acts "as a calmer of the nervous system; it modifies at the same time the bronchial secretions, which it dries up; it has also antiseptic properties, which enable it to act not only on the symptoms, but on the course of the whooping-cough."

Of all the new remedies, Talamon would give the preference to terpine, especially if the pertussis is accompanied by an abundant catarrhal secretion. The

following formula, in which terpine is associated with antipyrin, is recommended:

Terpine, 1 to 1.50 grammes;
Antipyrin; 1 gramme;
Syrup of orange-peel, 50 grammes;
Linden-water (or mucilage) 60
grammes.

Dose.—From 1 to 2 teaspoonfuls several times a day to a child of from 1 to 4 years of age.—*Therapeutic Gazette*.

EXPERIMENTAL INFECTION WITH MILK FROM TUBERCULOUS COWS.

Dr. Karl Hirschberger has made, at the request of Dr. Bollinger, a series of experiments in the Pathological Institute at Munich on the inoculation of animals with milk from cows in various stages of tuberculosis. He attempts to answer the following questions:—1. Do tuberculous cows frequently give infectious milk, or is their milk only exceptionally infectious? 2. In which forms of tuberculosis is the milk infectious—in localised or only in general tuberculosis? He made twenty experiments, and calls attention to the fact that inoculation alone can give decisive results, because it is very difficult to observe tubercle bacilli microscopically in the milk, and impossible to discover their spores. On the strength of his experiments he states that the danger of infection from the milk of tuberculous cows does not only exist, but is very great, being found in 55 per cent. of all cases examined. The more the tuberculosis has spread the greater is this danger; but even in mild cases of localised tuberculosis the milk is, he considers, more or less infectious.—*Lancet*.

ANTIQUITY OF MAN.

Considering that the Section of Anthropology in the meetings of the British Association is scarcely more than twenty years old, it must be admitted that it has proved itself a vigorous offshoot of the

tree of biological knowledge. The special interest that attaches to all questions dealing with the present and past condition of the human race is felt by the layman as strongly almost as by the scientist, and there are few who have not of late years pondered on the primitive condition of the ancestors from which we are descended. Professor Rudler, in his opening address, observed that of late years there has been little cavil in accepting as a recognised fact that both on the continent of Europe and in these islands man existed during the quaternary period and was contemporary of the mammoth and hairy rhinoceros and of other animals, several of which are either entirely or locally extinct. More recently others have sought to establish his existence in far earlier tertiary times, the evidence on which they rely being the presumed discovery of parts of the human skeleton; the existence of animal bones, said to have been cut and worked by the hand of man; and, lastly, the discovery of flints, thought to be artificially fashioned. After consideration of each of these links in the chain of evidence, Professor Rudler feels himself compelled to reply, "Not proven," his reasons being that the tertiary period, with its three divisions, known as the eocene, miocene, and pliocene, included a vast period of time, and were marked by great changes in the forms of life. So that of the vertebrate land animals of the eocene no one has survived to the present time, whilst of the pliocene but one—the hippopotamus—remains unmodified. The chances that man, as at present constituted, should also be a survivor from that period seem remote, and against the species *Homo sapiens* having existed in miocene times almost incalculable. The origin and home of the Aryan family are of still greater interest. That the cradle of this family was in the highlands of Central Asia is no longer generally admitted. The Germans contend that the primitive Aryans were the blue-eyed dolicephalic race, of which the Scandinavians and North Germans are typical

examples, whilst the French are in favour of the view that dark-haired brachycephalic race of Gauls, now well represented in the Auvergne, is that of the primitive Aryan. Some help may be derived from the comparative study of languages and grammar, but Professor Rudler thinks too much stress must not be placed on linguistic palaeontology, but admits that much information may be obtained by a careful examinations of the admirable collections of prehistoric ages in the great museums of Europe, as well as from those illustrating the manners and customs of existing tribes. At present no positive statement in regard to the antiquity of the human race can be given.—*Lancet.*

EAR DRUMS.

Having recently received several inquiries as to the efficacy of artificial ear drums as a remedy for deafness, it appears advisable to say a few words on the subject. Certain experiments have been much extolled and advertised, and have in this way been recommended to the suffering public for many years. A moment's consideration will show that as a general rule they are not only useless but highly injurious, being applied by those interested without examination of the patients, who in most cases possess a membrana tympani which is already too thick and dense to admit of vibration. Artificial ear drums are useful only to those who have perforation or complete absence of membrane, and even then only a small proportion are benefited by artificial drums. Should a case really requiring some form of artificial drum come under the notice of an aural surgeon, all rigid contrivances, which are intensely irritating and injurious to the delicate mucous membrane of the tympanum, would be avoided, and a small roll of cotton or absorbent wool moistened with glycerine and water would most likely be used. It should, however, be remembered that cases suitable for artificial drums of cotton wool are always in a condition bordering on recurrent in-

flammation of the tympanic cavity, with all its dangerous consequences. It will thus be seen how highly it is that applications of this kind should be made only by those who really understand such diseases. Certain much-vaunted drums are given, or rather sold, by quacks to patients suffering from all and every kind of deafness to such an extent that nearly 90 per cent. of patients have another rigid drum placed upon a natural drum which is already too dense. Practical experience very soon convinces the victims of the danger and folly of thus tampering with Nature's delicate organisms.—*Lancet.*

ANTISEPTICS AMONG THE ANCIENT GREEKS.

Prof. Andreas Anagostakis, of Athens, gives in the *Deutsche Medicinische Wochenschrift* some interesting facts in reference to the employment of antiseptic measures among the ancient Greeks. Hippocrates and Galen were aware that an unclean condition of wounds retarded healing. They were also well acquainted with the fact that by thorough haemostasis, suture and the employment of antiseptic measures, infection of wounds might be prevented. Hippocrates warned his disciples against the use of moist dressings, on account of the danger of suppuration, and forbade the employment of drugs before the wound was dry. Above all, says Galen, avoid dirt, as it prevents healing. The ancient Greeks boiled water before applying it to wounds. Sponges were avoided, and charpie recommended in their stead, which was to be destroyed after use. One of the principle antiseptic substances then in use was wine, which was usually heated before using, and with which, according to Hippocrates, all wounds were to be washed. Dressings dipped in wine were also applied to the wound. Salt was in very general use, either in solution or in the form of sea-water. The solutions were rendered aseptic by boiling. Sulphate of copper was relied upon as an antiseptic for foul

wounds, and was also put into use as a haemostatic. Tar was highly praised for its antiseptic virtues, and was either applied in the form of a dressing or directly poured upon the wound. Besides these, many aromatics and bitters were in daily usage, among which were thyme, rosin, asphaltum, etc., used as dressings, or in the form of plasters. Galen was acquainted with catgut, and advised the use of non-putrefying substances for sutures. Prof. Anagostakis declares that all this was not empiricism, but an antiseptic method founded upon some knowledge of the principles governing the healing of wounds.—*Druggist's Circular.*

THALLIN IN TYPHOID FEVER.

Dr. F. Schmidt, in his graduation thesis at Berne in 1889, reports the results which he obtained in the employment of thallin in twenty-two cases of typhoid fever, the remedy being given in doses varying from $\frac{1}{2}$ to 3 grains in a day with nothing given at night. The following are his conclusions (*Les Nouveaux Remèdes*, July 24, 1890):

1. The mortality of typhoid fever treated by thallin is less than that obtainable by any other mode of treatment.
2. Thallin, in the doses above mentioned, distinctly reduces the temperature in cases of moderate intensity, but in typhoid fever of extreme gravity this dose is insufficient. It also would seem that the patients support thallin better than cold baths.
3. In general the duration of the disease is not diminished, although this effect would appear to occur in a few isolated cases.
4. No unfavorable secondary action was noted either on the heart or lungs. There was no collapse or irritation of the kidneys. Nevertheless, basing his conclusions on the results obtained by other authors, Schmidt advises the withholding of thallin in all cases where renal lesions have been detected.
5. Thallin maintains a favorable influence on the sensorium in all cases of

typhoid fever except those of extreme gravity.

6. Complications and relapses are not prevented by the use of thallin any more than by any other form of treatment.

7. If it is impossible to discover any specific action of thallin on typhoid fever, at least it would appear that certain effects exist which render this action probable.

Finally, the author considers the treatment of thallin in the majority of cases as in no respect inferior to that of cold baths, and in cases where there is a rapid progress of the disease would even seem superior. After having analyzed the thesis of Schmidt, Rutimeyer adds that he has never observed collapse even after doses considered excessive, even more than $7\frac{1}{2}$ grains being given. In this amount thallin appears to clear the brain in severe as well as in milder forms of typhoid fever.—*Therapeutic Gazette.*

SYRUP OF HYDRIODIC ACID IN ASTHMA.

In the *Medical Bulletin* for September is an interesting article by Dr. A. E. Norton, of Philadelphia, on the advantages of hydriodic acid in the treatment of asthma. He thinks that a larger percentage of asthmatic cases would be benefited by treatment if more attention were paid to the source of irritation, whether from dust, climatic influence, syphilitic taint, heredity, etc. In treatment two great principles should be borne in mind: first, to avoid or remove the exciting cause, and second, to allay or prevent the spasm. When heredity is the predisposing cause there is usually faulty development of the lung-structure, which should be corrected as much as possible by proper gymnastic exercise to develop the chest-structure. Other cases, due to climate, idiosyncrasy, the inhalation of irritating dust or vapors, must be dealt with according to the cause. Another class of cases are those in which the disease may be fairly ascribed to the inheritance of a gouty or

specific diathesis, to which may be added those in which the causation cannot be positively determined; these are most frequently benefited by either iodides, mercurials, or arsenical preparations. To Dr. Norton it has seemed that the best results were obtained from the iodine treatment, and it is to the best methods of administering iodine that he calls attention. Potassium iodide does not usually afford much relief unless administered in quite large doses, which promote nausea, anorexia, and general gastric irritability, due to the liberation of potassium. To avoid these evils he has for several years employed hydriodic acid in syrup form, by the liberal but discriminating use of which he has obtained better results than have attended the use of any other remedy in his hands. Among the advantages offered by the syrup of hydriodic acid are its acceptable taste, freedom from irritation, and its greater energy, promptness, and certainty of action. These advantages have been verified in a number of cases, and he has learned to rely on the drug in this, as well as in other diseases. The syrup may be given in teaspoonful doses, frequently repeated at first, and its prophylactic use may be continued for some time after the more urgent symptoms have subsided. It has acted very effectively in a wide range of cases, both of short duration and of long standing, and its effectiveness would seem to warrant its more wide spread use.—*Weekly Medical Review.*

ON THE NATURE AND TREATMENT OF ECZEMA.

Unna writes on the above subject in the *British Journal of Dermatology* for August, 1890, and makes a strong plea for the specific nature of the disease. He believes that the true and essential cause is the inoculation of a germ, probably of vegetable nature. The germ, however, proliferates in the epidermis and its appendages only, when the soil is suitable for its growth.

The various predisposing and exciting causes which have previously been regarded as the sole causative factors must now be regarded only as preparing the nutrient basis for the reception and proliferation of the germ.

The congenital nature of the skin (heredity), supervening diseases, especially those which alter the skin secretions (rheumatism, gout), changes in the skin tissue such as take place at the various periods of life (dentition, menstruation, climacteric), and other intercurrent diseases of the skin (acute exanthemata) —can be all considered as predisposing causes, or, better, as pre-existing improvements of the nutrient base. External warmth and moisture, simple inflammations and stases, as well as all external irritants, may be described as exciting causes, or, better, as accidental improvements of the nutrient base.

The parasitic theory, then, instead of denying all the previous observations which have been made on ætiology of eczema, requires them as essential auxiliary causes. In defining eczema, Unna modifies slightly the definition of Erasmus Wilson, and calls it *a chronic parasitic catarrh of the skin, with desquamation, itching, and the disposition to respond to irritation by exudation, and well-marked inflammation.* The author concludes his interesting article as follows:

1. The treatment of chronic eczema may be considered with advantage under two heads: *a.* By the use of antiparasitic measures the germ itself is attacked. This is the direct treatment. *b.* On the other hand, by it the epidermis, which is the nutrient soil, becomes less suitable for the growth of the specific germ. This is the indirect treatment.

2. The radical treatment of eczema aims at the destruction of every single germ in the depths of the epidermis.

A disappearance of the eczema efflorescence is by no means equivalent to a thorough cure of the disease, which is, however, always attained by the prolonged and continuous use of specific measures.

3. There are various chronic eczemas, which may be distinguished with certainty by their clinical symptoms and course. They do not by any means always pass through the so-called "stages" of eczema, of which we hear so much, but each form has its type, its own variations, and of course its own specific treatment. As examples I may quote the eczema of scabies, the seborrhœic eczema, follicular eczema, and papular eczema.

4. As the therapeutics of these ætiologically different eczemas is not the same, I will limit myself to special suggestions for that variety which is the most common—viz: the seborrhœic eczema. This begins as a desquamative erythema, similar to pityriasis, and continues as such, or develops either into an oozing eczema, or into squamous or crusted psoriasis-like eruptions. When it becomes vesicular it is chiefly from the effect of external irritation.

For the treatment of this eczema we possess as specifics strong alkalies, several metallic oxides, and the reducing group of medicinal agents. In this series of specific remedies the most worthy of mention are caustic potash, zinc oxide, lead oxide, mercuric oxide, sulphur, resorcin, pyrogallol, chrysarobin, and the various kinds of tars.

5. The choice of the remedy and its form of application are determined in seborrhœic eczema, as in all forms of eczema, by the degree of inflammation which is present.

When the inflammation and oozing are pronounced, the milder specifics are indicated, such as zinc oxide, lead oxide, sulphur, resorcin, in the form of powders, lotions, pastes, and glycerin gelatinous. When the inflammation is less and the dryness greater, the stronger specifics, such as chrysarobin, pyrogallol, tar, and mercuric oxide, are indicated, especially in the form of salves, salve mulls, plaster mulls, and waterproof dressings.

6. It may be taken as a general rule that among the remedies and modes of

application those must be selected for each case which will produce the most powerful effect on the specific germ (direct or indirect) without exciting an artificial inflammation. A really "irritating" treatment is not necessary, even in the case of the oldest and dryest eczemas; if only provision is made for thinning down the horny layer (an ordinary sequence), the specific agents will have the desired effect without any irritation whatever. Indeed, an irritating mode of treatment of eczema is only justified on principle when it is used as a test to spots which are apparently healed, in order to recognize the presence of any surviving germs which they may still contain. The alternation of anti-eczematous and provocative treatment corresponds to Tyndall's interrupted sterilization.

7. The only internal remedy which exercises any specific though limited influence on seborrhœic eczema, and especially on its drier forms, is arsenic. All other forms of treatment of the general organism, and of other organs which have a direct association with the skin (such as the bowels, uterus, kidneys), all dietetic cures, all baths (except sublimate baths), may be considered only in so far as they may possibly assist the local treatment of the skin in an indirect way.

8. In the search for new specifics against the various forms of eczema, their harmlessness for the general organism must be taken into consideration, and with regard to the reducing medicinal agents in particular it must be noted whether there is an absence of irritating properties in their oxidation products.—*Journal of Cutaneous and Genito-Urinary Diseases.*

INSANE MEN AT BASE-BALL.

A number of patients from the Friends' Asylum for the Insane in Philadelphia were taken recently to witness a base-ball game. They enjoyed the antics of the players and imagined that they were visiting another institution for

incurables. They expressed sympathy for the hallucinations which beset the poor creatures who jumped, danced, ran forward and backward, and slid on the ground so frantically.

Since their visit it is said the patients have much improved, and the *Philadelphia Record* says it may yet come that ball grounds all over the country will have places on the grand stand set apart for this class of visitors, and that those interested in the care and treatment of the insane will take their patients to witness the games as a curative by comparison.—*Med. and Surg. Reporter.*

THE NUCLEI OF BILIARY CALCULI.

According to Dr. Naunyn of Strasburg, biliary calculi, though they appear to have gathered round a cholesterin nucleus, do not arise primarily from masses of this substance, but from some soft matter shed by the walls of the biliary passages, which becomes impregnated with cholesterin, not so much from the bile, perhaps, as from the catarrhal secretion of the mucous membrane of the biliary passages.—*Lancet.*

HOSPITAL NURSES.

There are many women entering the profession of nursing, whose sense of honor is not high, and whose appreciation of the dignity of labor is not great, but who see in nursing either the means of gaining a livelihood, or a way to escape from the rather dull and petty routine of a single girl's life at home. They like the *éclat* of doing a noble work, and the independence which is essential to it, but are unwilling to do more work than they can help to attain their desire. There are, however, other women who, in taking up nursing, often as a means of livelihood, do so with the highest motives, and who, in rendering themselves independent, have at the same time the great pleasure of helping others in their struggle through life. From this class come all our best matrons, sisters, and nurses, and to them is due the high posi-

tion nursing holds as a profession for women.—*Murray's Magazine*.—*Medical Record*.

TREATMENT OF GOITRE.

Even in this country where goitre can not be said to be endemic, the practitioner must meet with not a few cases of chronic enlargement of the thyroid gland. The fact that females suffer more frequently than males from this disease, and that the consequent disfigurement is more felt by them, renders treatment frequently necessary, and happily in the majority of cases this is successful, especially in the "acquired" form, which is the common form in America, and which rarely manifests itself until after puberty. Leaving aside the endemic variety, the chief causes of the sporadic form are, first, heredity, which is noted in the majority of cases; next, changes in the circulation connected with the sexual functions in females such as menstruation, pregnancy, child-bearing, and, lastly, all occupations which favors stasis of blood in the veins of the neck, as carrying heavy weights on the head, etc. Any of these causes may be noted as active in the cases met, and as change of residence can not be looked upon as important in their treatment, the question of cure, becomes purely a medical and surgical one. Fortunately in the great majority of cases medication by means of the iodides, combined with counter-irritation over the gland, is sufficient to cause the resolution of the growth, but in not a few instances more active measures have to be undertaken, the swelling proving intractable to the measures mentioned above.

The remedy which has proved most efficient is iodide of potash, in doses of five or ten grains two or three times a day. At the same time the swelling should be rubbed with some preparation of iodine, either the ointment or the tincture. Dr. Felix Semon recommends a combination of one part ungu. iodi. to two to four parts ungu. pot. iodidi.

Another local application which has been markedly successful in India, is the ungu. hydrarg. iodidi. rub., 15 grains to the ounce. This is to be smeared in for a few moments over the whole surface of the goitre, which is then to be exposed to the full rays of the sun as long as the patient can endure it. Within half an hour a blister forms, which should be treated in the usual way. It is said that the tumor will decrease day by day for weeks, when a second application may be necessary. Macnamara, Cunningham, F. Mouat and other observers, speak very highly of this method of treatment and its value seems to be beyond question. Other methods are the application of liq. epispasticus, B. P., as advocated by Sir Morell Mackenzie; the permanent application of cold by Leiter's tubes, to be worn twice in the twenty-four hours for a period of three hours. Various other remedies have been used with success, as strychnia, ammonium chloride, and fluoric acid. The latter given in doses of fifteen to sixty minims largely diluted, three times a day is said (Woakes) to have caused the disappearance of the tumor in seventeen cases out of twenty.

When all the above means prove useless, the parenchymatous injection of the gland with some irritant, or its excision, only remain to be attempted. The latter operation is, however, so often fatal, and if successful is so liable to be followed by myxœdema, that it is only to be undertaken when, other means having failed, the condition of the patient is such that the surgeon may hope to give a margin of life to the sufferer by undertaking it. It is said that leaving behind a small portion of the gland obviates the danger of a subsequent myxœdema. The operation of resection of the isthmus performed a few years ago by Mr. Sydney Jones, for the relief of the dyspœa, dysphagia and cough of goitre, and which promised so well, the lateral lobes of the gland having been said to shrink after the operation, has apparently fallen into disuse, little or nothing having been heard of it for five or six

years. So that the only operation left is the interstitial injection of some irritant fluid into the gland. Numerous substances have been used and with success. Very lately Professor Mosetig, of Vienna, has been using iodoform. He injects 15 to 30 minims of the following solution: iodoform 1; ether 4; olive oil 9. He has found that in each of 79 cases so treated there has been a decided decrease in the neck. In substernal goitres the injection of a superficial part seems to be successful. He says that as compared with iodine as an injection the advantages of iodoform are that inflammatory complications never occur, suppuration never having been observed by him.

Ergotin, tincture of iron and Fowler's solution have also been used, but with not perhaps as much success as tincture of iodine. This is the remedy recommended by the great majority of surgeons and lately by Terrillon, surgeon to the Salpêtrière, who has had large experience with this and other remedies used parenchymatously.

He makes the following observations as very necessary for the operator to note:—

"1. Be sure to penetrate the substance of the tumor before pushing the injection. 2. Avoid, as far as possible, transfixing the veins which ramify in the cellular tissue on the anterior aspect of the neck. The patient should be made to take a full breath, during which the swollen jugulars become prominent. 3. Have a hypodermic syringe that is clean, in order to avoid the introduction of infectious germs. Leave the syringe with its needle for a certain time in boiling water before using."

The veins may easily be made prominent also, by winding a piece of tape round the base of the neck and they will be thus avoided, a matter of much moment.

The needle should be pushed boldly but slowly into the gland to the depth of at least four-fifths of an inch, in order to avoid infiltration of the cellular tissue of the neck, which causes suppuration. He counsels, that when the needle is

pushed in, the bowl be unscrewed, leaving the needle open at the base, to see whether any blood flows from it. This is an extra precaution to prevent injecting iodine into a vein. Of course if blood flows another place is chosen and dealt with in a similar manner. The syringe is screwed on and seven or eight minims of pure tinct. iodine is injected. The needle should not be immediately removed, otherwise, the fluid would follow its course and infiltrate the cellular tissue instead of being diffused in the parenchyma of the gland. Usually the patient experiences nothing more than a slight pain and a little swelling, and then the quantity is increased as may be desired. The injections should be made one at a time and a few—four or five, days apart in order to guard against iodism. Even if the pains be rather severe in the lower jaw, teeth, back of the neck, shoulder or chest they need not give alarm as they usually quickly subside. Suppuration is rare if the technique of the operation be perfect.

One injection has been known to cure a goitre, but usually they have to be repeated, frequently up to say twenty, to produce a cure. The action of the agent is to produce cicatricial tissue at the place where injected, which by shrinking at the various points produces atrophy of the gland, in a similar manner to the liver by increase of fibrous tissue caused by any undue irritation. The goitre undergoes a fibroid transformation.

It may seem unnecessary to caution the operator about going *too deep* with the needle, but Semon's plan of having the patient swallow with the needle in position is a good one. By noting the movement of the needle inserted into the gland one may be sure whether its point is beneath, in, or above the tumor, a matter of the utmost importance.—*Canada Lancet*.

ANTISEPTIC LIQUID.

The following formula is in use in some of the hospitals and dispensaries as an antiseptic dressing:

R.—Boric acid	240 grains.
Salicylic acid	30 grains.
Water	2 pints.
Dissolve.	

—*Med. and Surg. Reporter.*

MUMPS AND INFLAMMATION OF THE LACHRYMAL GLAND.

A short time ago a paragraph appeared in the *British Medical Journal* on certain affections which make their appearance during epidemics of mumps, and are presumably allied to that disease. At a meeting of the Société Vaudoise de Médecine in June, M. Dufour exhibited a drawing which represented a case of acute inflammation of the lachrymal glands, occurring during an epidemic of parotitis in the district where the patient dwelt. A gardener was attacked with rigors and feverishness on the day after hard work under a hot sun. The eyelids began to swell, next day there was a distinct swelling in each upper lid, which continued for three days. At the end of that date the lachrymal gland, enlarged to the size of a cobnut and hard as cartilage, could be felt on each side. The palpebral cleft was triangular, with the apex at the inner canthus; the symmetrical character of the affection was marked. Two days later all fever had passed away, the tumours had diminished in size, at the end of three days they were of the dimensions of a small bean, the lids had resumed their normal aspect. A fortnight later, three weeks and four days after the initial rigor, a tough body the size of a pea could be felt under each upper lid at the outer canthus. The patient was in good general health. Professor Hirschberg, of Berlin, described two similar cases which occurred during the past spring at Berlin. Dr. Epéron noted that, whilst inflammation of the orbital portion of the lachrymal gland is rare, the palpebral or lower portion is more frequently inflamed, constituting an affection doubtless mistaken in many instances, for a stye in the outer part of the lid.—*British Medical Journal.*

Medical Items.

Dr. Ehrlich has been appointed Extraordinary Professor of Medicine at Berlin.

Southern California is said to be a thriving place for every one except doctors.

Dr. G. Betton Massey has removed his offices and Sanitarium to 212 South Fifteenth Street, Philadelphia.

Physicians who have been resident physicians at summer hotels, report a prosperous season for themselves.

A chiropodist announces that he has removed corns from several of the crowned heads of Europe.

Dr. James Mathews Duncan, late Lecturer on Midwifery in St. Bartholomew's Hospital, has died in London. Dr. Duncan was born in Aberdeen.

There is a pleasant prospect for the young doctor that small pox, cholera, and influenza are all three making themselves prominent at present.

The transfer of the Marine Hospital Service from the Treasury Department to the Naval Medical Service is said to be contemplated.

The late Dr. Henry Muirhead left £25,000 (\$125,000) in his will to found a college of medicine and dentistry in Glasgow for women.

During the last week of July one hundred candidates entered their names as candidates for the degree of M. D. in the Faculty of Medicine in Paris, and of this number nine were women.

The daily papers report the death of Dr. James M. Smith, one of the oldest physicians of Allegany county at the advanced age of eighty-seven years, at his home in Cumberland.

There would appear to be a recrudescence of influenza in Vienna. Several cases are stated to have occurred in the hospitals there. In Paris also the disease is said to be reappearing.

It is reported that typhus fever has broken out in the district of Rybuik, Upper Silesia, and twenty persons are suffering from the malady on the large estate of Modlisszevko, in the province of Posen.

Beginning with the August number, the *Buffalo Medical and Surgical Journal* appears in new type. Drs. John A. Miller and De Lancey Rochester have been added to the editorial staff. This is one of our most acceptable exchanges.

The Boylston Prize, of the Harvard University, for 1890, amounting to \$200, has been awarded to Dr. H. A. Hare, for an essay entitled, "The Uses and Value of Antipyretics in the Treatment of Fever."

The General Council of the Haute-Garonne has drafted a petition for the establishment of a university at Toulouse, and the mayor of that city has opened a subscription list for the benefit of a medical faculty to be attached to the university.

The ordinary obstetric fee in the interior of China, according to a writer in the *Medical Missionary Journal*, is among the better classes two dollars, when the child proves to be a boy, one dollar for a girl. Among the poorer one dollar for a boy and fifty cents for a girl.

There is a curious law in France which decides upon the precedence among twins by asserting that the one born last is the elder. This law is based, it is said, upon the statements of certain medical authorities consulted by the government, who came to the conclusion that the last born of twins was the first conceived.

A midwife in Prussia has been sentenced to imprisonment for three years and a half for continuing to practise after having been forbidden to do so temporarily by a physician and by the police. She was held to have been the direct cause of the death of one woman after confinement, and of the serious illness of another.

It is now stated officially that the statements as to the prevalence of leprosy in New Caledonia were due to a mistaken diagnosis. The disease is now stated to be "not leprosy, but a simple skin disease," probably the severe form of ringworm which is known to be very prevalent among the inhabitants of the South Sea Islands.

A decimal point is a small point for a human life to hang upon. It was a point so indistinct in a New York physician's prescription that the druggist put up 75 grammes of aconite, instead of 7.5 grammes as intended. The mother of a sick baby, for whom the medicine was given, tested it by tasting from the bottle and was killed.

The third Italian Congress of Internal Medicine will be held in Rome on Oct. 20th, 21st, 22nd, and 23rd. The Committee, presided over by Dr. Baccelli, and composed of Professors Cantani, Murri, Maragliano and Rossini, have decided that the following shall be the topics of special discussion:—1. The Etiology and Treatment of Pleurisy. 2. The Pathology of the Blood. 3. The Varieties of Polyneuritis.

According to French practice, the physician is a preferred creditor only in case of the patient's death, and then only to the extent of his fees for attendance during the last illness; but, as we learn from the *Lyon médical*, a French court has recently decided in favor of the claim of a Dr. Benoist as a preferred creditor of a patient who recovered, but became in-

solvent. The decision overruled that of the assignee, and the costs fell upon the estate.

During the past few years the subject of hygiene has received marked attention from the German government. In nearly all the leading universities there are now hygienic institutes, thoroughly equipped in every way. Recently the new hygienic institute in the University of Halle was opened. The institute has a lecture room, and also special chemical, physical and bacteriological laboratories.

A woman died recently in Omaha from exhaustion following a protracted labor. The coroner's jury found that the woman had come to her death from heart failure, caused by exhausting labor pains and the depressing effects of the anaesthetic. The jury further found from the evidence submitted that the medical attendants upon the case were negligent in their duty in failing to perform the operation of Cæsarean section.

The *Medical Record* is responsible for the following:—The Medical Practitioners' Protective Alliance is the name of an association formed in Baltimore, with the object of maintaining organized co-operation among practising physicians, for the purpose of protecting themselves against the dispensary abuse and inferior medical schools, and of devising means of improving their financial condition in every honorable way. Dr. J. H. De Wolf is the secretary of the association.

Louisville has no ambulance system, but an effort is being made to induce the city authorities to establish one. Baltimore has many hospitals, some of them quite large, but none have an organized ambulance system. The University of Maryland has an ambulance, but not modern enough to deserve the name. The Johns Hopkins Hospital has a very handsome modern ambulance, but either because it is too heavy for the streets, or because the authorities are

afraid of getting it scratched, it has never been out.

The following remarkable story has been going the rounds of the daily press:—"The wife of John Beam, of Mitchellville, N. Y., aged 55 years, gave birth to twins Monday evening of last week. Her daughter, Mrs. Stratton, who lives in a neighboring township, presented her husband with twins the same evening. Mrs. Stratton's daughter Eva was married a year ago, and lives in Bradford. The friends of Mrs. Stratton and her mother were not yet through congratulating them over the interesting natal coincidence in their families when Mrs. Stratton received a letter from her son-in-law announcing that her daughter had given birth to twins herself on Monday evening."

The Maryland State Homœopathic Medical Society will hold its next annual meeting in this city on October 8th, at its hall in the building occupied by the Maryland Homœopathic Free Dispensary and Hospital, No. 323 N. Paca street. The president, Dr. Elias C. Price, will preside, and a large number of members from all over the state have promised to attend and participate in the proceedings. The Baltimore members are actively engaged in preparing papers to be read at the meeting. The Medical Investigation Club of Baltimore will present a study of the symptomatology of kali bicromicum. Dr. N. W. Kneass, "A New Method of Drainage in Abdominal Surgery;" Dr. H. F. Garey, "Gelsemium in Ocular Troubles;" Dr. F. C. Drane, "Placental Complications." Several other papers whose titles are unknown will also be read and discussed.

During the meeting the hospital of the Maryland Homœopathic Free Dispensary will be opened for the reception of patients. This will be celebrated with a banquet in the evening, tendered by the city members to their brethren in the state and invited guests from Washington and other cities.

MARYLAND MEDICAL JOURNAL.

VOL. XXIII. No. 23. BALTIMORE, OCTOBER 4, 1890.

NO. 497

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PERFORATION OF THE VERMIFORM APPENDIX.*

BY V. M. REICHARD, M. D.,
OF FAIR PLAY, MD.

I was called on the night of Saturday March 29, 1890, to see a case with Dr. E. S. Downs of Williamsport, Maryland. We saw the case about midnight. Chas. D., aet. 22, tall, broad-shouldered and muscular, his physique suggested the perfection of young manhood. He had never had any serious illness and few persons ever heard him complain. For months, however, he had been taking various nostrums, cathartic pills, blood purges and all that host of clap-trap nonsense by which designing men catch the cash of the unwary. He was at this

time teaching school, and the change from an active life on the farm to a sedentary one, led to his constant medicine taking. In morals and habits he was perfectly correct; he was in his usual good health on Wednesday, March 26. On Thursday he complained when at school, of crampy pains in his abdomen, but kept on with his work. His pain must have been rather severe, as he spoke to a number of persons about it, at different times in the day. That evening, however, he ate an exceedingly hearty supper, and remarked to his aunt, with whom he made his home, that she should after this, prepare him just as much dinner as would go into his satchel. About 2 A. M. Friday he was taken with a very severe pain in the abdomen, and Dr. Downs was sent for. Taking it to be a case of intestinal colic, he gave a half grain of morphia and left him a few cathartic doses of calomel. Charles was out of bed all day Friday, but was not feeling well. He was lying on a sofa most

* Read before the Washington County Medical Society August 13th, 1890.

of the time. His bowels were opened several times and he always walked out to the water-closet some distance from the house. Saturday at 9 A. M., Dr. Downs saw him again, and although he was in bed there was nothing in his condition to give anyone grave concern. In the afternoon Dr. Downs was again sent for, and finding his patient decidedly worse, asked that I might be called. At midnight his condition was as follows: Temperature $100\frac{1}{2}$ °, pulse small and weak, 120, lying in bed with knees drawn up and a heavy expression of countenance. This expression might have been due to the morphia which had been given. Abdomen full and distended; tympanitic over the entire surface below the ribs except in the right iliac fossa, where an area of dullness as large as the open hand was made out on deep percussion. The abdomen was moderately resisting, but extending his legs gave him no pain. The liver dullness was normal. His pain at this time, was not great, but was described as having begun acutely in the right flank both on Friday morning and Saturday afternoon. His urine was scanty, and as dark as strong coffee, and he voided it every few minutes. His desire to pass water almost amounted to strangury. An examination of the urine, made later, revealed nothing abnormal except an excessive quantity of bile pigment. Nothing abnormal was found above the diaphragm. His general appearance was indicative of shock rather than intense suffering.

Diagnosis.—General peritonitis due to perforating appendicitis. In my own mind the steps of the process were inflammation and ulceration due to a foreign body, perforation on Friday morning with resulting circumscribed pericecal abscess, which latter opened into the general peritoneal cavity on Saturday afternoon, giving rise to the general peritonitis I found. I advised morphia hypodermically and opium between in large enough doses to quiet him. Turpentine stupe to the abdomen. At Dr. Downs's request I assumed charge of the case.

Sunday, 8 A. M. He had a grain of morphia and ten grains of opium; he is not resting well; complains of pain; abdomen as hard as a board. Not the least impression could be made upon it by such pressure as he could stand. Bladder as night before, extremely thirsty, tongue red and glossy looking, but not dry. Mind fairly clear, pulse moderate in volume 125, temperature $100\frac{1}{2}$ °. Being rather surprised to find so low a temperature, the thermometer was inserted into the rectum and registered $103\frac{1}{2}$ °. Same treatment continued except to give ice freely, milk in full quantity.

6 P. M. Pulse 140, temperature in rectum 104° . Condition unchanged except bladder more quiet and he hiccupped once in the half hour I was with him.

Monday, March 31, 8 A. M. Belly as hard as a board, pulse at the wrist could not be counted. By listening to the heart sound, made it out 160. Temperature in the rectum $104\frac{1}{2}$ °, bladder paralyzed, was relieved with a catheter. Wandering delirium. Hiccup constant, sank and died at 10.30 A. M.

Autopsy.—At 11.30 P. M., rigor mortis extreme. The arms could scarcely be turned aside to permit section. Only the abdominal cavity examined. On section in the median line the distended intestines filled up the incision completely. Visceral layer of peritoneum covered with shreds of lymph, and extravasated blood. It had everywhere lost its shining and transparent appearance. Incisions were made at right angles to the first one. Within two inches on the right side the pus began to well up. Continuing the incision I soon came upon a layer of recent lymph which had all the appearance of the wall of an abscess. This cavity (for such it proved to be) was opened up and a large quantity of pus flowed out. The wall of the abscess cavity extended anteriorly nearly to the edge of the rectus muscle of the same side, and upward to the liver, covering the whole of the under surface of the right lobe of that organ.

and gluing its edge to the parietal peritoneum, thus cutting off the superior surface of the right lobe from the general peritoneal cavity and explaining the continuance of the liver dullness. In tearing open the abscess cavity I was startled at the appearance of the gall-bladder. It was enormously distended and covered with lymph and pus, and for a moment I thought I had an hepatic abscess opening into the peritoneum. Further examination revealed the true nature of the enlargement. As the body had been embalmed, it was impossible to estimate the exact quantity of pus in this cavity, but from what I have seen of the amount of preserving fluid injected in other cases there was in this case at least a quart of pus.

Continuing, the head of colon was sought. Everything was so matted together with lymph as to require some careful searching and dissecting to bring it into view. After severing all adhesions, the cæcum was brought up into the light, and there on its blind extremity lay what looked like a large black worm. I passed the back of a scalpel blade over it, and gas and liquid faeces bubbled out, and then I knew I had found the cause of all the trouble. The ileum and colon were tied and severed, the mass removed entire and laid aside. Beyond this nothing was found except the general peritonitis.

(Specimen exhibited and described). As you will see the appendix was adherent to the cæcum in the whole of its extent. The union is so intimate that it could only be separated by the most tedious and careful dissection. The middle segment of the organ was gangrenous. Two irregular enlargements stood out prominently in this region. Several perforations existed but they were surprising by their minuteness. The tube was opened and the enlargements found to be irregularly angled intestinal concretions. One of these was bisected, and its structure was found to be arranged in concentric layers. At a number of the

angles on both secretions, small, hard particles came to the surface. They looked like minute bits of quill tooth pick. In every perforation one of these hard bits presented. Some spots were noticed where only the peritoneal coat was intact. All the others had disappeared from the inside pressure.

Remarks.—The appendix is covered normally by peritoneum in its entire extent. It is a part, anatomically of the cæcum. Its function, if it has one, is the same as the function of the cæcum. Professor Chapman in his recent book on physiology, says the cæcum in man with its appendix is the remains of an organ which in some of the lower animals is functionally active, and does the work of an extra stomach. "There is," he says, "an inverse ratio both anatomically and physiologically between the stomach and cæcum; when the one is small and inactive, the other is large and active, and vice versa." If we are somewhat in the dark as to its physiology we have, however, a tremendous flood of light thrown upon its pathology showing forth some of the saddest and most painful scenes we are called upon to witness. There is no more ferocious attack upon a man's life from the inside of his economy than that which results from this perforation.

Causation.—The direct and immediate cause of this accident is of course, an ulcer. As to whether a simple, so-called idiopathic inflammation can cause perforation there may be some difference of opinion. My own conclusion is that it never does. It is opposed to all analogy. No other hollow viscus takes on a simple catarrhal inflammation which goes on to perforation. There is always a direct structural reason why such perforation takes place. It is an embolus plugging an artery causing necrosis and sloughing. It is an inflammation following special gland tissue as in typhoid ulceration. It is a specific poison deposited along a vessel as in tubercular ulceration. A catarrhal inflammation may cause obliteration or

so fill up the cavity with its products as to lead to pressure outward, and consequently ulceration. But that simple idiopathic ulceration may lead to perforation, I can not for a moment accept. Nor, indeed, in case of perforating appendicitis, need we accept it for all the evidence points the other way.

Fitz says, as a rule, the appendix contains faecal matter of greater or less solidity. In 169 fatal cases studied by Matterstock 53 per cent. were due to intestinal concretions, and 12 per cent. to foreign bodies. In Fitz's study of 157 fatal cases, 47 per cent. were due to concretions, and 12 per cent. to foreign bodies. Dr. Morton operated on six cases, and found concretions in five of them. In the vast amount of pus which is poured out around the cæcum and the consequent disturbing and disorganization of tissues, it is no wonder that the foreign body or concretion is so often missed. Indeed the wonder is that it is so often found. My idea of the modus of the perforation is this:—The concretion grows layer by layer. So long as the diameter is not much in excess of the diameter of the tube there is no trouble. If, however, it becomes inordinately large, the liquid part be absorbed, or a hard particle come to the surface, or all of these happen together, there is pressure upon the inner surface of the organ, and it gives way layer by layer as was shown so beautifully in my specimen. I do not believe perforation of the appendix ever takes place except when due to pressure from within, or more rarely to tubercular or typhoid ulceration.

Diagnosis:—Up to the time of perforation I do not believe that appendicitis about which we hear so much just now is diagnosable by the average physician in the present state of our knowledge. An expert makes a diagnosis of appendicitis, an operation is done and an appendix is removed containing soft faeces (the so-called results of catarrhal inflammation) or showing signs of inflammation more or less remote. This last shows nothing, for Fitz long since stated that one-third

of all cadavers he examined showed evidence of appendicitis. Unfortunately in my own autopsies I kept no record of the condition of the appendix. Aside from some ordinary colicky pain, more or less indefinite, and the so called bilious state, we are at present absolutely without definite knowledge on the subject. I have seen a number of cases in which I might have said there was appendicitis, but in the only case in which I was absolutely sure of it there was nothing to call attention to the organ before the fatal perforation. In the vast majority of cases the patient is not seen until the perforation has taken place. When this accident happens, one or both of two conditions may arise at once or in close sequence.

A general peritonitis may at once be lighted up, or a pericæcal abscess may form which sooner or later bursting into the peritoneal cavity will cause a general peritonitis. By far the more usual occurrence is for pericæcal abscesses to open in this way.

When perforation results in pericæcal abscess, for a few days care must be taken not to confound it with faecal typhlitis. Points on which the diagnosis will turn are, the greater amount of fever and general systematic disturbance in abscess than in impaction. Pain is not of so much importance as impaction may be ushered in by such severe pain as only to be controlled by large doses of morphia. However, the pain is much more likely to be localized in the right iliac fossa in abscess than in typhlitis. In the latter the pain is apt to be colicky and may be referred to any part of the abdomen. The fever does not go so high in impaction as in abscess. It is rare to have it above $99\frac{1}{2}^{\circ}$ in the former, whereas it is nearly always above 100° in the latter. The difference, though at times slight, must have great weight in the diagnosis. In typhlitis there is little depression of the vital powers. In abscess the system shows the presence of pus by the general appearance,—what Prof. Da Costa calls the "physiognomy of disease."

The tumor in faecal typhlitis is more

knobbed and doughy generally than in abscess, and its long diameter corresponds more nearly to the course of the bowel. In faecal typhlitis the bowels are obstinately constipated, and in abscess may be easily moved. Add to this that impaction is a condition without urgent symptoms, and a little time will clear it up by removing the obstruction, and abscess is frequently most urgent in its calls upon us and demands prompt action, and we have nearly all the points of difference.

Indeed the difference is so slight as to make it at times extremely difficult to recognize. I know of no condition which disturbs me so much as a faecal impaction. Its possibilities are so grave and its prognosis so uncertain that my mind is always filled with the direst forebodings. In a case at all urgent, I should not hesitate to explore the region thoroughly with the needle of a hypodermic syringe. If the case of faecal typhlitis goes on unrelieved it may cause a so-called perityphlitic abscess, but I believe the condition is exactly like that arising from perforation of the appendix. It is very much to be desired that the terms typhlitis and perityphlitis be dropped, and cæcitis and pericæcitis be substituted. Pericæcal abscess I believe, in both cases, to be due to perforation. The hard faecal mass by pressing against the cæcum causes it to give way just as in appendicitis. The presence of pus having been decided upon the indication is plain. Evacuate the pus, resect the appendix and wash out the cavity. In the large majority of cases long before this the abscess would have burst into the peritoneal cavity, and what was a dark and undiagnosable affection before, now becomes one of the clearest and most deadly of accidents. Fitz says, "Pain sudden severe and constant was the first and most decided symptom in 85 per cent. of the cases. Its onset represents the extension to the general peritoneum." General peritonitis is set up, and now the condition of the patient is the same whether the perforation open at once with the serous cavity or an abscess form-

to subsequently burst inwardly. The patient's life is in the most deadly peril. Now there is no time to await developments. False steps here, and delay, means death. Everyone is agreed as to the terrible rapidity of the disease when the general peritoneum is involved. Professor Da Costa in his impressive lecture on this condition called it "a thunderbolt from a clear sky." We must at once decide what we will do. These cases all die if left alone. We might as well tie a fifty-six pound stone to a man's neck and sink him in ten feet of water and expect him to live as to expect a patient to survive a general peritonitis due to faecal or purulent infection. Nothing short of a miracle will save life if left alone. Modern surgery has made it possible to save a large proportion of these patients. I have watched with a great deal of interest the rise of the operation for perforation of the appendix. Laparotomy was advised frequently but was not resorted to successfully until on April 27th, 1887 Dr. Thomas G. Morton operated upon a patient in whom Dr. Woodbury and Dr. James C. Wilson had diagnosed perforation of the appendix. The man recovered and represents the first successful operation done with a clear intention from the beginning. Since then there have been quite a number of successful operations and there is now no question about the status of the operation. Indeed, it looks as if in the near future the dictum of surgery will be "operate on every case of general peritonitis" for I believe that general peritonitis is traumatic in the very large majority of cases. I believe we are just at the beginning of a new era in the pathology of the peritoneum and modern gynecologists will yet teach us to open the abdomen in every case of general peritonitis.

According to Morton the point of selection is two inches internal to the anterior superior spinous process on a line from said process to the umbilicus, cut down, excise the appendix and wash out the general peritoneal cavity with hot

boiled water. Better not use chemicals in the peritoneal cavity. Even Lister the apostle of chemical antisepticism, advises only the weakest solutions, here 1 to 10,000 of the double cyanide of mercury. Irrigate until the water comes away perfectly clear. Insert a drain tube low down in the pelvis and close the external wound lightly with the interrupted suture. Look for the great swelling which Morton has spoken of, and cut the sutures if necessary. All this is just what I did not do, and it will ever be a source of regret that I did not urge an operation at once on seeing him on Saturday night. I do not believe the family would have consented as they would not recognize the gravity of the case until he was dying on Monday morning. As I made the post-mortem and saw the condition existing there, I was entirely convinced of the futility of anything short of an operation for excising the appendix and washing out the peritoneal cavity. I then and there registered with myself a vow that never again would I let a patient die without the chance of an operation when I was so clear as to the condition existing.

THE DIAGNOSIS AND TREATMENT OF THE SIMPLER EYE DISEASES.

BY HERBERT HARLAN, A. M., M. D.,
OF BALTIMORE.

Assistant Surgeon Presbyterian Eye, Ear, and Throat
Charity Hospital, etc.

(Continued from page 462.)

Interstitial Keratitis.—This is a form of inflammation of the corneal tissue proper and as it appears in young persons, is in the majority of cases due to inherited syphilitic or scrofulous taint. It is very commonly associated with the notched and irregular teeth, Hutchinson's teeth. It begins with a localized clouding or haziness of the cornea, gen-

erally at the upper margin. This extends slowly until the whole cornea is of a ground glass appearance, and at times there is a complete network of very fine blood-vessels throughout its entire substance. There is not much pain, but some photophobia. The sight is very defective and often reduced to little more than light preception. Both eyes are attacked, but most frequently at a considerable interval, the second eye being attacked at about the time the first is getting well. The progress of this disease is slow, often continuing many months, but the prognosis is favorable and after a time the eyes clear up. Some opacity, however, often remains for a long time.

Constitutional Treatment is all important. Small but continued doses of mercury, along with iodide of potash, in the cases associated with Hutchinson's teeth or other evidence of inherited syphilis, and in all cases tonics and the best food with open air and exercise, are indicated. Locally, much benefit is derived from

Ry.—Atropiae sulph. gr. ii.
Aquaæ ʒ i

M. Sig. A drop in the eye t. d.

When the eyes are improving, but the leukoma still makes the vision very imperfect, these opacities may be very much hastened in clearing up, by having calomel dusted into the eye once daily, and applying massage by rubbing the eyeball with the fore-finger on the outside the lids.

Iritis.—Inflammation of the iris is to be attributed most frequently to syphilis, and the next most common cause is rheumatism. Probably seventy per cent. is due to syphilis, twenty to rheumatism, and ten to other causes, among which may be mentioned traumatism.

The diagnosis is to be made between iritis on the one hand, and conjunctivitis, scleritis, and cyclitis. Here again, a careful inspection is all important. In conjunctivitis there is little or no pain;

in the others a good deal. The diagnosis is most readily made by noting the reaction of the pupil to light. With the eye not under consideration closed, let the lids of the painful one be alternately opened and closed in a good light. If the pupil remains contracted, or responds only very sluggishly to the sudden changes of light, iritis is present. In blue or light grey eyes an inflamed iris often is seen to be a shade darker than the healthy one; in black eyes the diagnosis is more difficult. In a dark room an ophthalmoscopic or an ordinary head reflector will show the pupil to be not only permanently contracted, but to have irregular edges. In iritis there is an exudation of lymph, and this causes adhesions to the anterior surface of the lens with which the healthy iris is lightly in contact. These adhesions in the beginning, are only in spots, and are easily broken up by dilating the pupil with some mydriatic, having this in mind, a drop of an atropia solution will clear up the diagnosis always in doubtful cases, because if the eye be watched as dilatation takes place, even when no adhesions have taken place, it will be seen to dilate irregularly. At the points where adhesion has already taken place, the pupil not being able to dilate, there will be seen points of iris as it were, projecting into the pupil. In recent cases, continued use of atropia will nearly always break up these adhesions. The danger in iritis is from these adhesions.

Treatment.—The first thing to be done is to get the pupil dilated. To do this I order

ʒ.—Atropiæ sulph. gr. iv.
Aquæ ʒ i

M. Sig. A few drops in the eye every two hours.

If a few instillations of the above dilate the pupil fully, then two or three applications daily will usually suffice to keep it dilated until all inflammation and danger have passed away. Next to dilating the pupil, it is all important to

remove the cause of trouble by appropriate treatment. In syphilitic cases the patient must be put on vigorous specific remedies. The same of the rheumatic cases. In bad cases, whether syphilitic or rheumatic, a few full doses of salicylate of soda are of great benefit.

R.—Sedii salicyl. ʒ iss.
Ft. Chart. No. iii.

Sig. One powder in half a glass of water every three hours.

Glaucoma.—This dreadful disease ought to be more promptly recognized by the general medical profession than is now the case, because, if the most benefit is to be derived from treatment, it must be begun before the eyesight is seriously impaired. The term is derived from a Greek word signifying green and refers to a greenish reflex from the pupil. The subjective symptoms are more or less impairment of vision, diminution of the visual field, the appearance of the rainbow colors about artificial lights and pain in the eyes. The attacks usually are at first intermittent, but occur at more and more frequent intervals. The objective symptoms are a partially dilated and immobile pupil having the above greenish reflex. On feeling the eye-ball through the lids, it is found to be harder than normal. The ophthalmoscope shows excavation of the disc, and at times pulsation of the retinal vessels. There is in some families a strong hereditary tendency to glaucoma, though in most cases nothing of the sort can be made out.

Treatment.—

R.—Eserine sulphate gr. i.
Aquæ ʒ i

M. Sig. A drop in the eye every three hours.

This is in many cases of great benefit, and in a few seems to be curative. The chief reliance, however, is to be placed on the operation of iridectomy. This, if performed early, usually arrests the

further progress of the disease, but the vision existing at the time of operation is very seldom made better. The evident moral of which is to operate as soon as the diagnosis is positively established, and not delay until vision is more seriously impaired.

317 North Charles Street.

REFLEX HEADACHE DUE TO NASAL NECROSIS.

BY ARTHUR SNOWDEN, M. D.,
OF WASHINGTON, D. C.

Headache is due to many causes, and while all the organs of the economy are held accountable for the many and varied forms of this most common affection, it is seldom the practitioner ever directs his thoughts to the nasal fossæ as a possible source from which the symptoms may arise. He may treat some imaginary uterine, liver, kidney, brain, or gastro-intestinal disorder, or he may refer his patient to an oculist, thinking he may find some fault with the accommodation, but rarely is his attention arrested by a history of chronic catarrh or an occlusion of one or both nasal fossæ. The average medical student dismisses this anatomical region with the thought that it is where the special sense of olfaction resides, forgetting that of three meatuses, only one is given to the fulfilment of this object, and that the other two are required for the purposes of warming, moistening and filtering the air in normal inspiration.

The mucous lining of the respiratory region, which comprises all that part of the fossæ lying below the superior turbinated body, is of the ciliated columnar variety. Beneath this is the basement membrane, perforated for the terminal branches of the tri-facial. Underneath this is found a mass of adenoid tissue, and in the deeper portion of the mucous

layer are a large number of mucous and serous glands. Now we come to the erectile tissue which is limited chiefly to the respiratory tract, and is seen in its greatest profusion on the inferior turbinated bodies. It is under the control of the sympathetic, and its overgrowth is due to over-stimulation of the so-called trophic nerves which are the vaso-motors.

The blood to this part of the respiratory tract comes from the nasal or spheno-palatine branches of the internal maxillary, a branch of the external carotid, and are under the control of the vaso-motor nerves coming from the superior ganglion.

The nerves of sensation come from the fifth and are the nasal branch of the ophthalmic, filaments from the anterior dental branch of the superior maxillary, V_i, dian, naso-palatine and anterior palatine.

Woakes says the ganglia distributed about the branch of the fifth and other cranial nerves really belong to the sinus of the sympathetic ganglia proper, and that they subserve the same function of determining the reflexes, and thereby correlating distant areas in regard to such impressions as pass to them.

Now then, having looked into the anatomy of this region, and seen from whence its blood and nerve supply comes we can theorize upon the effect of the turgescence or hypertrophy which follow repeated attacks of acute rhinitis. We know that an impression received at some distant point, for example; a chilling of the feet or draught upon some part of the body will cause or produce a coryza in these catarrhally predisposed, or a derangement of the alimentary tract will often bring about the same state of affairs. In an individual whose nasal fossa there is always more or less stuffiness or occlusion, due either to hypertrophy or that condition of turgescence or œdema which precedes true hypertrophy we see an acute attack produced by one of the foregoing causes. Whereas the individual before had the lumen of one or

*Read before the Clinico-Pathological Society of Washington D. C., May, 20th, 1890.

both fossæ narrowed, he now has total occlusion and pressure upon the septum, due to the superadded engorgement of the turbinated bodies. "Why, if," as Woakes says, "the ganglia distributed about the branches of the fifth and other cranial nerves really belong to the sympathetic and subserve the same function of determining the reflexes, could we not have this impression due to pressure on the terminal branches on the fifth in the nasal fossæ reflexed by correlation to the supra- or infra-orbital region?" The question might be asked with great propriety, why do not all individuals who have deviation or thickening of the nasal septum suffer from headache when they take cold? We answer that the neurotic habit or element is lacking. At any rate in those individuals who suffer from violent paroxysmal or persistent headache and who possess a highly nervous temperament, peripheral irritation in the nasal fossæ should be looked for, as it is a well known fact that nasal polypi, en- chondroma, exostosis, nasal deflections and adenoid tissue at the vault of the pharynx cause increased sensory excitability. In conclusion I report three cases.—

S. R. Broker, 32 years of age, suffered from severe attacks of supra-orbital neuralgia which lasted from a few to thirty-six hours. The attack began with a flickering sensation in the left eye, followed by pain over the supra-orbital region which however radiated in all directions when its maximum intensity was reached. There would occasionally be retching and vomiting followed by much prostration. There was a well marked patch of gray hair over the course of the nerve. He had suffered from his youth, and the only relief was from the use of morphia. His general health was good and the only thing he complained of beside the headache was a chronic catarrh. Upon questioning him he stated that before each of these attacks he noticed his nose was stopped, and he could not breathe through the left side at all. I examined the nasal cavities and

found the turbinated body on the left side much enlarged and encroaching upon the septum. This was reduced with the galvano-cautery since which time he has had no return of his neuralgia, but has had very occasionally what he says is an ordinary headache from which anyone might suffer, but not severe enough for him to neglect his business or take to bed. Eyes examined.

J. S. Coachman, 35 years of age, had been kicked in the face by a horse 18 months before, since which time he had had violent attacks of headache or neuralgia which seemed to follow colds. The pain was always over the right eye. Upon examining the nasal fossæ I found the right side nearly occluded from a deflection of the septum, also hypertrophy of the middle and lower turbinated bodies. The hypertrophy was reduced but he declined an operation upon the septum. He has been suffering from neuralgia since. Eyes not examined.

E. G. Gail, engineer, 36 years of age, general health good. He had been a sufferer from neuralgia for the past five years. Came to me to be treated for chronic catarrh. Gave history of neuralgia following every fresh cold taken, and found upon examination hypertrophy of middle and inferior turbinated bodies. When the hypertrophy was reduced neuralgia ceased. Eyes examined.
1272 N. H. Avenue.

The Hufeland Society in Berlin offers two prizes of 700 marks (\$175) each; one for a treatise on the Influenza Epidemic of 1889-90, the other for one on the Legal Responsibility of the Physician in the Application of Chloroform and other Inhalation Anæsthetics. The first must contain a history of previous influenza epidemics and of that in question, and an account of the causes, symptoms, and treatment of the latter and its sequelæ. The treatises must be sent to Professor Liebreich of Berlin before April 1st, 1891. These prizes are paid from the interest of a fund established by the Portuguese physician, DaCosta Alvarenga who had studied in Berlin.

Society Reports.**MEDICAL AND SURGICAL SOCIETY
OF BALTIMORE.**

STATED MEETING HELD MAY 8TH, 1890.

Dr. A. Friedenwald spoke on**INJURIES TO THE EYE.**

He said it is difficult to say what the outcome of an injury to the eye may be in all cases. Sometimes an injury that may appear slight may prove disastrous to the eye, again, one that may look formidable when received, will heal promptly without any injury to sight whatever. In considering this subject, it is as well to consider each part separately, but one injury may involve a number of the parts.

Injuries to the lids: burns, lacerations &c. In burns of the lids, if extensive, deformity is apt to follow, causing ectropion. There is nothing that can be done to avoid the deformity that follows cicatrization. The ectropion has to be remedied by subsequent operation. In lacerations of the lids, deformity may be avoided by careful adaptation of the parts. Use plenty of thin silk sutures under aseptic precautions, and the lids will heal promptly.

Injuries to the conjunctiva: burns, if superficial, give little trouble, but if extensive and the two opposing surfaces of the lid and eye-ball, be denuded of their epithelium, these will unite in healing and cause symblepharon.

Lacerations of the conjunctiva give little trouble, as the conjunctiva bears sutures well. One of the most common injuries to the conjunctiva is a foreign body. The patient usually comes to you with the diagnosis. Should the patient insist that "there is something in there," you should credit his statement and carefully examine again. The usual seat of lodgement for a foreign body is under the upper lid.

Foreign bodies in the cornea are more formidable, sometimes they are extremely minute and escape attention unless well looked for. Lateral illumination usually brings them into view. In removing them, a few drops of cocaine should be instilled in the eye. Sometimes a patient will be so restless that a speculum will have to be introduced and the eye grasped with a pair of fixation forceps. After instilling the cocaine, fix the eye and remove the foreign body with a spud or cataract knife or needle. If it be a solid body, as a bit of iron or steel, it can be removed easily, but if it be emory or a bit of oxidize metal, it is more difficult. Do not make too great an effort to remove it all, as by so doing the cornea may be injured. It is not necessary to remove all. If the mass which rises up above the level of the cornea and scratches on the conjunctiva of the upper lid be removed, that which lies below the surface of the cornea may be absorbed. We have illustrations of this in tattooing an opaque cornea.

Puncture of cornea: the cornea may be incised and it heals readily in a short time, scarcely any tissue will bear an injury better, but a ragged incision, especially if made by an instrument conveying septic material is bad. This is especially so in oyster shell injuries. These are best treated by instillations of a bichloride solution 1:5000 preceded by cocaine to allay irritation, follow this with iodoform. Wounds do better when dressed with iodoform, even though bacteria live in it, as claimed. When the cornea is punctured, we should ascertain as soon as possible how deep the instrument has penetrated. We may not be able to tell immediately, but it will soon show itself. If the lens be injured it will become cloudy in 24 hours. The iris does not bear injuries well. Puncture of the iris is supposed to be a serious accident. Injury to the lens is always to be looked upon as serious, the best we can hope for is absorption of the lens, even this is serious as it deprives the patient of accommodation. It is serious for the further reason that the diffused image in

the bad eye disturbs the image in the good eye. Injuries to the lens are better born by a young person than by an older one. The child will shut out the bad image, not by shutting the eye as an older person will do, but by throwing the eye out of the visual axis, and thus produce an internal or external strabismus. When such an injury is sustained by a young person, dilate the pupil with atropine and watch it. Sometimes we may safely leave such injuries to nature, and an absorption of the lens takes place. Again the lens may swell to such an extent as to obliterate the whole anterior chamber, when it becomes necessary to open the cornea and let out the offending substance.

Blows: the anterior chamber may be filled with blood as the result of a blow, this, of course, obscures the deeper parts from our researches. A simple haemorrhage into the anterior chamber may be quickly absorbed, but we should always be guarded in our prognosis. We may have a rupture of the capsule, and a cataract or a rupture of the choroid, which, of course, cannot be recognized until the haemorrhage is absorbed and the media becomes clear. The blow may rupture the sclera, the usual seat of a scleral rupture is in the anterior part. Here we should not hesitate to introduce sutures. We must also take into account that a blow may produce concussion of the retina, and produce permanent blindness, or a paralysis of the sphincter of the pupil.

Injuries to the orbit may be caused by blows or by instruments, and may be serious, though an accident of this kind may occasionally give little or no trouble, as in the case of a child who was struck with a slate pencil, $\frac{3}{4}$ of an inch of which broke off and remained in the orbit for three weeks before it was removed. During this time the child was not inconvenienced at all, nor was there any injury to movements or to the sight of the eye. A simple, copious haemorrhage into the anterior chamber may increase the intraocular pressure to such an extent as to cause an atrophy of the optic nerve, resulting in blindness.

The optic nerve does not stand pressure very well, as in the case where the point of an umbrella was accidentally plunged under the lower lid and it produced blindness by causing an atrophy of the optic nerve.

Dr. Harry Friedenwald said in burns of the eyelids he would suggest transplantation on the granular surfaces. To avoid the excessive ectropion produced by cicatrization following burns, he had seen the suggestion somewhere, of producing ankyloblepharon by suturing the edges of the lids together and close both lids until all contraction of healing should take place.

In making a simple division of injuries to the eye-ball, he would divide them into two classes, those that open the coats, and those that do not. In all cases where the coats are left intact, there will not develop any sympathetic trouble. Foreign bodies are of importance, especially in a manufacturing city like ours. They usually lodge under the upper lid, but occasionally they may penetrate. A patient came into a hospital with the history of a foreign body. An examination was made and nothing was found, he was given an acetate of lead solution and dismissed. He went to another hospital after this and by careful examination a small scar was found in the cornea, the iris and the lens. He finally developed panophthalmitis, which is the greatest danger to injured eyes.

Dr. F. C. Bressler said he had a case of a man who was struck by the crank handle on an oyster boat. He had a fractured nose and haemorrhage in the anterior chamber of the eye. When the haemorrhage cleared up, there was found a dislocated lens and rupture of the central artery, causing total blindness. Another case of a farmer, who gave a history of foreign body, on examination, a piece of hay one inch long was found under the upper lid. Another case where the patient had received a wound in the ciliary region. The choroid was protruding through the lips of the wound. He instilled a few drops of eserine and

advised him to go to the eye hospital, where the wound was sewn up; with good result.

Dr. S. J. Belt asked what would have been the result, in the case of a woman who had received a quantity of sulphuric acid above the eye, causing a considerable destruction of tissue, with ectropion, if the lids had been sewn together?

Dr. A. Friedenwald said he had no experience with this method. While it might do in moderate cases, he did not think it would avail in the case cited by Dr. Belt. Sympathetic ophthalmia is apt to follow injury to the ciliary bodies. He thought Dr. Bressler's case, where the choroid was protruding through the lips of a wound in the ciliary region, would develop sympathetic ophthalmia if watched long enough. He had a case, where, having him in a hospital under close observation, he could be watched carefully. He congratulated himself on having a case that would not follow the rule and dismissed him. He returned in a short time with a great deal of pain and the eye was removed. When an eye is injured with loss of vitreous and there is no doubt that it will be useless, he thought it best to remove it at once and not wait for eventualities. The patient would be in no worse condition than he would be if he were subjected to an operation after prolonged suffering.

Dr. W. S. Gardner read a paper

ON PYÆMIA.

Dr. J. W. Chambers said he was glad that Dr. Gardner had to go back three or four years to get a case to relate. He was satisfied that in the near future, we would have to go back to the old literature to find out anything about pyæmia. The joint lesions are not spoken of in the books; all of Dr. Gardner's cases had foci in the joints. When you have a case of pyæmia you should open every abscess you can get at, as you will thus lessen the number of foci of infection. Last summer he saw four children with pyæmia. This is a rare affection in children. There was no tuberculous

history in these cases and one of them is now a healthy, robust child. There is no other diagnosis to offer; they all recovered, each of them had several abscesses which were opened and washed, and thoroughly drained. They were put on nourishing diet and stimulants.

Dr. David Streett said he had a case of a child with varicella, followed by pyæmia and about twenty abscesses developed from the little points of varicella.

Dr. R. G. Davis asked why were the joints almost always affected? Can you have pyæmia without a wound? He saw a young man who wrenched his back in driving a young colt. An abscess about $2\frac{1}{2}$ inches over the crest of the ilium, another just above the crest of the ilium and still another on the shoulder were opened. Then the left knee gave him trouble, but no abscess formed. Afterwards he went to New York where he was operated on for necrosis of the vertebrae.

Dr. W. S. Gardner said most of the books say that the lungs are most frequently affected, but he agreed with Dr. Chambers that the joints are most frequently affected. Why? He had heard or read somewhere, that the capillaries about the joints are finer than in other situations and thus offer a better nidus for embolism.

Dr. F. C. Bressler said the capillaries about the joints are more tortuous than elsewhere, so as to admit of the free movements of the joints, and it is for this reason that it is thought the capillaries offer a better nidus for embolism.

Dr. Bressler then read a paper entitled

TOXIC EFFECTS FOLLOWING THE APPLICATION OF EMPLASTRUM CANTHARIDIS.

Dr. Chambers said he did not think the thickness of the plaster made any difference, it was not so much the thickness of the plaster as it was the surface it covered. He thought that little if any absorption continued after vesication.

Dr. Gardner said he believed the extent of surface is of more importance in

its toxic effects than the length of time the plaster remained. Is it not reasonable to suppose that a strong plaster over a given surface will have more effect than a mild one of the same size?

Dr. Streett said he thought the patient was particularly susceptible, in that he showed strangury in five hours. He had used cantharides plasters for seven hours without producing any unpleasant symptoms. He thought the length of time of more effect than the amount of surface covered, and that strong cantharides acts more by its local effect than by absorption.

Dr. Belt said he agreed with Dr. Gardner as to extent of surface and thought the pharmacist should not be censured for giving a plaster that would do the work.

Dr. Bressler said the plasters remained on for eleven hours, and he did not believe that absorption ceases with vesication, but that absorption still goes on. He was not finding fault with the quality of the plaster, but that there was too much of it.

J. WM. FUNCK, M. D.,
Reporting and Recording Secretary.
1710 W. Fayette Street.

PILOCARPINE AS AN ANTAGONIST TO BELLADONNA.

In the *Lancet* for July 26, 1890, Dr. William McGowan writes that a little before noon on December 25, 1889, he was called to visit a married woman, aged about 37, who was said to be dying from having taken a quantity of a liniment by mistake for a dose of a mixture she had been ordered.

On examining the bottle, it was found that she had taken a large tablespoonful of belladonna liniment, and her condition was at that time very serious. She was totally unconscious and breathing ster torously; there were frequently recurring convulsions; the pupils were widely dilated, so that there was only a ring of iris, and they were not influenced by light; the extremities were cold, the heart greatly excited and weak, and the pulse

scarcely perceptible at the wrist. She presented all the appearances of approaching death. Some attempt had been made before the writer's arrival to procure vomiting, but without success. As she could not swallow, Dr. McGowan injected $\frac{1}{2}$ of a grain of apomorphine. This failed to produce vomiting, and, fearing the depressing effect sometimes produced by the drug, he did not repeat it, but at once introduced the tube of the stomach-pump, and thoroughly washed out the stomach. The stomach was almost empty, and no odor of belladonna could be detected in the water returning from it. He then injected hypodermically $\frac{1}{2}$ of a grain of pilocarpine, passed the catheter, and withdrew nearly a pint of urine, injected a pint of strong hot coffee into the rectum, and used flagellation with a wet towel over the chest and cheeks, and mustard was applied to the calves of the legs. In about half an hour improvement was observed; her countenance became more natural. A little later she looked about her, and was soon able to swallow small quantities of sal volatile and coffee. About five hours later, Dr. McGowan, on returning, found the patient sitting up in bed, in a rather excited condition, and talking deliriously. The author injected another third of a grain of pilocarpine. It did not at any time produce perspiration, but only a little softness of the skin. From this time recovery was uninterrupted. She complained of thirst and dryness of the throat, and remained very weak, being unable to get up for nearly a week.

This case is worthy of record, on account of the apparently antagonistic influence of the pilocarpine to the belladonna. As over four hours had elapsed from the time the poison was taken until Dr. McGowan saw her, the belladonna must have been entirely absorbed, as indeed, was clear from the absence of odor of belladonna in the washings of the stomach, and from the very marked and characteristic effects. Although he used the stomach-pump, he does not attach much importance to this part of the means adopted.—*Therapeutic Gazette*

MARYLAND MEDICAL JOURNAL

Weekly Journal of Medicine and Surgery.

WILLIAM B. CANFIELD, A.M., M.D., Editor

Subscription \$3.00 per annum, payable in advance.

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No. 209 Park Avenue. BALTIMORE, MD

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BALTIMORE, OCTOBER 4, 1890.

Editorial.**THE GRATUITOUS WORK OF PHYSICIANS.**

There is no profession or business in which the members do so much for nothing as the medical profession. With the idea that the labor of assisting suffering humanity should be one of love, physicians are called on to attend hospitals, dispensaries, institutions, etc., with the hope that they will become much better known. What other business or profession works for nothing in order to gain a reputation? Surely not lawyers; for how many cities possess a legal dispensary, or how many business firms

give away their wares free one hour each day in order to gain a reputation? None in this city.

Again, physicians are supposed to attend free other physicians and their families, poor widows, protégés of wealthy patients, clergymen and their families, and very often druggists. To make all these people pay for what they got would be impossible. Yet they do not have their clothes and groceries given them free.

Of all these beneficiaries, the clergymen are generally the ones who get the most, and who, in the large cities, deserve it the least. The best paid clergymen in our large cities, living in houses free from rent and taxes, free from the expenses of lavish entertainments, which their calling often prohibits, are in almost every case much better off than the physician who gives them his skill and time free. Many clergymen are grateful and give some equivalent for the free attendance, and some physicians have the good sense and business tact to charge all clergymen, except, perhaps, their own. Such business principles are proper and help the younger men in the unequal competition. This leads to a statement that if all the older physicians would charge the full fee for their work, the younger men would have a much better chance. To show the gratitude of physicians, it may only be said that as recently as last Sunday a Baptist clergymen of this city is quoted in the daily papers as saying that one reason men do not keep pure is that (according to an authority quoted by him), fully ninety per cent. of physicians advise young men to visit brothels. This statement is quoted by a clergymen who possibly, indeed, very probably, gets his medical

service gratuitously, and yet who contributes his little mite to degrade a noble profession. If physicians would only be brought to the point of making all those who can pay, pay the proper amount, they will elevate a noble profession and help beginners who not only practise medicine, because, as the old ladies say, "they can do so much good," but who rely on the results of their work for a living.

THE TREATMENT OF THE SIMPLER EYE DISEASES.

Although the division of medicine into specialties has become necessary with the advance and extension of medical science, still the general practitioner will always exist, even if he is only to be found in the less thickly populated districts. Such a man must have enough knowledge of all diseases to give them at least the right start in the direction towards cure. Beyond a certain point specialists, when available, should be consulted. General practitioners in their family work often come across eye cases, which they cannot afford to send to specialists and such cases they treat with the best skill they possess. In the simple forms of eye diseases, a consultation is not generally necessary; it is only when the case becomes obscured or aggravated that a specialist should be sought.

To provide the general practitioner with a few practical points on treatment, of the simple eye diseases. Dr. Herbert Harlan, in the past few issues of the JOURNAL, has laid down the more modern treatment of those cases generally met with by the practitioner, in a clear and concise manner. With this number the

series is concluded, and although it was intentionally made not to cover the whole ground, still the more common diseases are described and their treatment given in an extremely satisfactory manner.

To every general practitioner the advice is given to read over these articles carefully; they are just long enough to cover the ground sufficiently, just short enough to be read without wading through unnecessary verbiage, and just practical enough to suit the large majority of cases that come up daily and puzzle the physician not skilled in the diagnosis and treatment of eye diseases.

Reviews, Books and Pamphlets.

Railway Surgery. A Practical work on the Special Department of Railway Surgery: For Railway Surgeons, and Practitioners in the General Practice of Surgery. By C. B. STEMEN, A. M., M. D., LL. D., Professor of Surgery in the Fort Wayne College of Medicine; Surgeon to the St. Joseph's Hospital, etc. With Numerous Illustrations. 8vo. Pp. 315. St. Louis: J. H. Chambers & Co. Price, \$3.

As a result of the large number of railroads in the West, and the frequent accidents, railway surgery has become a special department of surgery, and its importance and magnitude may be seen on glancing through this book. Most of the injuries need immediate attention, and the operations are often done under the most unfavorable circumstances and surroundings. The leading chapters are on the transportation of injured railway men, temporary treatment and shock. Railway concussion is another form of injury which the railway surgeon meets with frequently. Colorblindness is a subject with which he must be familiar. The hands and feet are such im-

portant members that great care and judgment are necessary when they are injured. Remembering their importance to all, but especially to the laboring man, the surgeon should act very conservatively and save as much of the hands and feet as possible. While this book is largely compiled from other works, still it deals with this subject from a different aspect, and in a way that almost makes it original. With the exception of a few minor typographical errors, the book is very well printed on good paper.

Familiar Forms of Nervous Disease. By M. ALLEN STARR, M. D., PH. D., Professor of Diseases of the Mind and Nervous System, College of Physicians and Surgeons, New York. With illustrations, diagrams and charts. New York: Wm. Wood & Co. 1890. Pp. 339. Price, \$3.00.

This is one of the most able books that has been written on this subject for a long time, and not only that, but it is a book that will give the general practitioner many a hint as to the diagnosis and treatment of many difficult diseases. It is based upon his experience gained at the Nervous Clinic of the College of Physicians and Surgeons, and the cases chosen are typical ones. The first part of the book is on cerebral localization, and from the list of authorities quoted at the end of each chapter, it is evident that the author has not neglected to study the literature of the subject very carefully. Drs. Winslow W. Skinner, Frederick Peterson and Walter Vought have each contributed to a part of this work. Not only is this treatment not neglected, but the author has a collection of tried formulae in the last chapter. The illustrations are good and the typography is much above the publishers' usual work.

Essentials of Anatomy and Manual of Practical Dissection, together with the Anatomy of the Viscera. Prepared especially for Students of Medicine. By

CHARLES B. NANCREDE, M. D., Professor of Surgery and of Clinical Surgery in the University of Michigan, Ann Arbor; late Senior Surgeon to the Episcopal Hospital; late Surgeon to the Jefferson Medical College Hospital; late Professor of General and Orthopædic Surgery in the Philadelphia Polyclinic, etc. Third edition, revised and enlarged, based upon the last edition of Gray's directory. Thirty handsome full-page lithographic plates in colors, and 180 fine wood-cuts. Small 8vo; pp. x.—388. Philadelphia: W. B. Saunders. 1890. Price \$2.00.

This is a little larger than the other "question compends" of the series, and as an adjunct to large works on anatomy may prove very useful for review. It is well supplied with an abundance of good colored plates.

Physical Diagnosis and Practical Urinalysis. An Epitome of the Physical Signs of the Heart, Lung, Kidney and Spleen in Health and Disease. Edited by JOHN E. CLARK, M. D., Professor of General Chemistry and Physics in the Detroit College of Medicine. 41 illustrations. Cloth, 12mo, 200 pages; price, postpaid, \$1.00. *Illustrated Medical Journal Co.*, Publishers, Detroit, Mich.

In the arrangement of this work the object has been to present to the medical student and practitioner a systematic and condensed course of Physical Diagnosis and Urinalysis. The portion on Urinalysis will be found to consist of two parts, practical and reference. The editor believes there is a demand, in many medical schools and by many medical students, for a short, definite course of organic chemistry, touching alone on those subjects of every-day interest to the medical practitioner, such as the analysis of urine, chemical and microscopical; the examination of sputa, bile, blood, bacteria, etc., methods for the

quantitative estimation of the more important urinary constituents, normal and abnormal, such as urea, chlorides, sugar, albumen, etc. To meet these requirements the editor has compiled this volume. Teachers in the laboratory will find the work of advantage as giving the plan for definite instruction with such manipulatory details as will enable students to pursue the course of urine analysis with the minimum of assistance. This is essentially the same as the course given by the editor in the college with which he is connected. Plates have been introduced as needed to still further assist in elucidating the text. The book is convenient as a pocket volume, but the type is rather small and indistinct for comfort.

Among the new books announced to appear soon are a new revised and enlarged edition of Rohé's "Hygiene," by Dr. George H. Rohé. This book has had a large sale. It is from the press of F. A. Davis, Philadelphia.

G. P. Putnam's Sons announces a new revised and enlarged edition of Canfield's Translation of Seifert and Müller's "Manual of Clinical Diagnosis." This edition will contain a handsome chromolithograph of the various bacteria and bacilli.

George S. Davis, of Detroit, will shortly issue "Practical Notes on Urinary Analysis," with numerous illustrations and colored plates. By Dr. Wm. B. Canfield.

THE TREATMENT OF SYPHILIS BY SUBCUTANEOUS INJECTION OF MERCURIAL PREPARATIONS.

Dr. Leloir and Dr. Tavernier, of Paris, having practised this method of treating syphilis in all sorts of syphilitic cases during two years, now (*Giorn. Ital. d. Mal. Ven. e. del Pelle*, 1889, xxiv. 247) give a statistical report of their experience and a summary of their conclusions (*New York Medical Journal*, August 9, 1890). In all they made fifteen hundred and seventy-three injections.

Of these, eight hundred and seventy-five were of 1 part calomel to 12 parts liquid vaseline, a half Pravaz syringeful being thrown into the sacro-lumbar muscles, and repeated once a week; six hundred and forty-two were of the yellow oxide of mercury, prepared and used in the same manner as the calomel; and fifty-six were of "gray oil," consisting of 20 parts of pure mercury, 40 parts of liquid vaseline, and 5 parts of the etheral tincture of benzoin, of which a third of a syringeful was injected every ninth day. They found, 1, that these injections acted specially upon the erythematous syphilide and upon the secondary cutaneous eruptions; 2, that the injections of calomel and of the yellow oxide, especially the first, often caused these eruptions to disappear with a surprising rapidity, or, as they named it, a "true brutality;" 3, that the calomel acts most intensely, and the gray oil least; 4, that all three are much more energetic in their effects than any internal method of medication, though much rougher; 5, that their action on syphilides of the mucous membrane, especially mucous patches, is very slight, and even while the injections are being practised, numerous mucous patches will appear; 6, that their action upon tertiary syphilides is very uncertain, as they very often resist the injections and have to be treated by inunctions and the local application of mercury. The principal inconveniences from this method of medication are the following: 1. The local or radiating pain caused by them, sometimes most violent, and capable at times of preventing walking. This may last from one to nine or more days. 2. Paralysis of the lower extremities. 3. Vertigo and headache. 4. Eruption of mucous patches in the mouth on the fourth or fifth day after the injection. 5. A mercurial dermatitis about the point of the injection. 6. Mercurial stomatitis, often slight, sometimes severe and long-continued. 7. A simple or bloody diarrhoea sometime during the interval between the injections. 8. Non-suppu-

rating cutaneous tumors, sometimes filled with a reddish serum. The treatment met with much opposition in hospital practice, many patients preferring to leave the hospital rather than to submit to it. Relapses seemed to be more frequent and precocious in cases treated by this method than in those treated by mercurial inunctions. The calomel injections produced the greatest number of disorders. The gray oil is the most inoffensive, but also the least active. The practical deductions from their experience are: 1. The use of subcutaneous injections of mercury should be limited to the early eruptions on the skin. They may be resorted to when it is necessary to produce a very rapid effect on these eruptions. 3. They are specially, if not exclusively, applied to hospital patients, or to those who can remain in bed for a few days. 4. It is a good means for treating prostitutes. 5. Its action upon mucous patches is very bad. 6. It does not prevent relapses. 7. In many cases it fails to cure, and recourse must be had to inunctions. 8. It should not be used against the late syphilitides except in those exceptional cases in which it is necessary to use mercury internally at the same time with its local use and the administration of the iodide of potassium. 9. It is contraindicated in cerebral and spinal syphilis, in visceral syphilis, in pregnant women, and in infants. The only advantage of the method is the rapidity of its action. But this advantage is more than balanced by its inconvenience.—

Therapeutic Gazette.

Correspondence.

VIENNA LETTER.

Vienna, September 15th, 1890.

Editor Maryland Medical Journal:

DEAR SIR:—Thinking that a letter from Vienna and from one connected with your city and the medical profession

there may be acceptable, I take the liberty to address one to you, to you, according to myself not only the privilege but the extreme pleasure of narrating the method of conducting clinics in the “Allgemeines Krankenhaus” in Vienna.

Vienna in itself needs no words of commendation from a medical standpoint, being recognized the whole world over as one the centres of our profession. Vienna is divided into 10 sections or divisions, but as only one of these interests us I will not burden you with the enumeration of them. I will only call your attention to one called the “Shöttenring,” situated in the northern part of the city, and containing within its boundaries all the hospitals, small and large, the clinics, the polyclinics and the university, which latter building is a fine massive structure resembling somewhat our Johns Hopkins Hospital on Broadway, only it is all together and not separated, its cupolas and domes rising in majestic magnificence and conveying the very air of learning and knowledge. We pass this university which is now closed, but soon to re-open as October is fast approaching, and as we leave this square in which the university stands we enter “Alserstrasse.” Who of my mates that have been to Vienna, and connected with hospital work does not remember “Alserstrasse?” As we enter it the long three story massive buildings on each side seem to shut out all else from the exterior. Further on to our right the long grey two story building attracts our attention and we find that it is the “Allgemeines Krankenhaus” of Vienna. At the General Hospital of Vienna, halfway along the front is a high arch-way with two large gates (wooden I think), one of which is open and through which is passing a crowd of “out-door” patients; but the crowd is not large, not as large as you would suppose from the size of the building. We enter now the portals of this hospital and find ourselves upon a flat sandy road which runs around the outer edge of the interior inclosure which again is

subdivided and crossed and recrossed by smaller roads and with trees in quite a goodly number; beneath the trees are benches, and upon these benches you see the patients who are convalescing and are out for a walk. The garb of these patients, to me, appeared anything else but appropriate for sick people. There were men and women all together, none that I could see had any shoes on but walked about freely in their stocking feet and had on a calico or blue faded gingham gown, which in the case of the men reached just just below their knees displaying undergarments, usually covered in the natural course of man's travel through this world. Some of the women were about covered the same, having a loose blanket or white night dress covering them and thus they sat about this court. The hospital extends around this court, and as I have stated is two stories high, in many places, the wards are on the ground floor, and hence the patients have access to the grounds. The wards are not all on the ground floor nor is the entire ground floor composed entirely of wards, but in many places the clinics are held on the ground floor, and again the clinics may be in the second story, however, entrance (Eingang) is always from the inner court.

We pass around from the right to left and see the Augenklinik, but as Professor Fuchs is not in Vienna we pass on, we pass the surgical clinic under Professor Albert and others, and at last we come around to the "ear clinic," and our attention is arrested for we know that Professor Adam Politzer, of the Politzer air bag renown, is holding his clinic. Come! will you enter with me? And introducing yourself to Professor Politzer see how he conducts his clinics. We pass through a narrow passage, turn to the left, open a door, and we find ourselves in a room well lighted up by windows with large panes of glass upon the wall facing the court, while in the opposite wall is only one small window, while in one corner is a wooden room as is seen so often in clinic rooms of

almost every kind, while in the wall opposite to the door through which we entered is another door leading into a private room.

The clinic room is small and is made much smaller by the presence of a long table which runs the length of the room, upon which are baskets with some bottles, rubber air bags, iodoform, alcohol and bicarbonate of soda and other drugs used in ear work, but not used here much as subsequent observations will show.

The clinic begins, and the patients being already in the room are asked to take seats in chairs arranged in a single row along the length of the room, and next the large opened windows (I forgot to mention that a portable black board was at one end of the room). Professor Politzer begins with the first, and there being only about five or six students present besides myself we have the full benefit and have ample opportunity to examine the cases. I will speak of two of them only, later, as they will serve to make the points I wish to emphasize, clear.

The material is quite sufficient, but by no means is the professor rushed as during the hour of the clinic. I know that not more than 20 cases appeared and were treated, however do not understand me to urge the idea, which I am afraid is a prevalent one in America, that one must treat so and so many cases in such and such a specified time to be a successful practitioner of his specialty, by no means is that my idea. The patient seated on an ordinary chair, and his head moved according to the conditions etc., the professor stands over him and throws the light through the rubber speculum into the external auditory meatus and down upon the tympanum of the ear, exploring the ear in the usual way and if clogged up by anything whatever the patient is turned over to a nurse to have his ear washed out in a mechanical way as I took especial care to watch her doing it, running the risk of her thinking it was new to me, and that she was teaching me something. I am quite convinced that the ear cavity was only super-

ficially cleansed, however, water was used and the further exploration was continued. Case after case was gone over explaining the points as they occurred, and demonstrated by drawings on the black-board which had the effect of being forcible and direct. Among the several cases I will mention two as examples, one was the very beautiful case of a perforation from otitis media and over the aperture of the perforation, a delicate film could be discovered as you threw the reflected light into the ear from the aural mirror and upon careful examination you could discern and distinguish regular and rhythmical pulsations of this film: the entire portion of the medium portion of the ear was intensely inflamed, and these pulsations were attributed to the presence of exudation upon the blood vessels being thus lowered and raised with each beat and pulse of the arteries. However this may be the pulsations were distinguishable clearly as I watched them for quite a while. This case was treated with a "Politzer" and dismissed (I might add here to those not acquainted with the nomenclature of aural treatment that a "Politzer" means sending a blast of air through the Eustachian tubes into the drum cavities by means of a Politzer air bag, hence called a "Politzer".)

The next case was that of a small boy (the former being a man of 28), who had an acute attack of inflammation of the tympanum or drum head alone, and the drum could be seen to be highly injected and the handle of the malleus standing out very clearly and surrounded by many injected blood-vessels, and I thought I distinguished an unusual concavity of the tympanum however, the drum membrane was much thickened with inflammation, and the question was, if it existed alone or was not accompanied by some otitis media, whether it was the case or not a Politzer was ordered and one of the assistants gave it. Many cases, I mean many in proportion, of old chronic adhesions of the drum membrane to the posterior wall were treated with a blast from the Politzer air bag, and with good results I am sure.

Before closing I would like to say one word about the method of administering the Politzer in the very place where it was originated, and under the direction of the very gentleman who invented this most useful means of inflating the cavity of the middle ear. I say without the least exaggeration that a Politzer is given in nearly 80 per cent. of all the cases.

The Method: In a basket on the table in the room are perhaps a dozen or 15 Politzer rubber bags, 13 have no nozzle or long rubber tube on them, the other two have, but the rubber tube has become useless from long continued neglect. This is the way it is done: the patients know what to expect, for they come regularly for the "Politzer," and they dread it, for in most of the cases the blast is driven down upon the diaphragm instead of into the Eustachian tubes, simply because the operator has not the proper control over the bag. Each patient who is a "regular," is provided with a small piece of rubber tubing which he brings with him and takes away with him. This is only a very small piece, an inch long, and is slipped over the projecting end of the "bag." What the use of this bit of rubber is I cannot see, for it certainly does not efficiently close the nasal aperture. The patient either takes a mouth-full of water and is directed to swallow, and in the act of swallowing, a slow blast of air is put into the pharynx because the Politzer bag is near the nose, and the operator must squeeze it with his hand and cannot give it a sharp squeeze as he could if he had a long rubber tube, and he could place the bag on his hip and mash it with a sudden movement of his whole arm. No, he must squeeze it with his fingers, and the consequence is, that the air is driven down the oesophagus, or down the larynx, and very little goes into the Eustachian tubes, and the patient soon learns to say "he felt it in his ears" because he wishes to avoid another.

I have seen many Politzers given at the Presbyterian Eye and Ear Hospital, and have given some myself, but I have

never seen the distress follow as I have seen in this clinic here in Vienna, and all because the proper force is not administered to the volume of air at the proper time.

I am sure the profession in Baltimore is on the right track as far as that is concerned, and I only mentioned this fact to show them how it is done here in Vienna.

Yours Sincerely,
A. D. MANSFIELD, M. D.

Miscellany.

COCA IN HOARSENESS OF PROFESSIONAL SINGERS.

The *Journal of the American Medical Association* of May 3rd, 1890, gives a valuable article entitled "Hoarseness in Professional Singers and its Treatment" by Chas. E. Sajous, M. D. Of great assistance in the treatment of these cases, is the use of coca wine when taken not only a half hour before the performance, but at the end of each act, so as to obtain the benefit of "toning" action when the next act is about to begin. That the "toning" action is not due to the wine proper, as some believe is demonstrated by the fact that sherry, the most alcoholic of all wines, does not at all give the singer smoothness and ease of execution obtained from coca wine; while liquors, such as whiskey and brandy, tend to increase hoarseness, if present, or to cause it if it is not.

ACUTE GONORRHOEA.

Schwimmer especially recommends the following injection in acute gonorrhœa:

R.—Salicylate of Mercury. .01 gr.
Water, 100. grs.

The injections to be used three times daily. At the end of three or four days

the discharge has, as a rule become mucous in character, when the remedy is to be discontinued. For chronic cases he recommends the same drug in a strength of five centigrams to one hundred grams of water.—*L'Union Médicale*.—*Journal of A. M. A.*

Medical Items.

Dr. G. Betton Massey has removed his offices and sanitarium to 212 South Fifteenth St., Philadelphia.

A Congress of Hydrology will be held at Naples towards the end of October under the presidency of Dr. C. S. Vinaj.

During the past year the Pharmacie Centrale of Paris made a net profit of 703,306 francs (about \$140,661).

A Bacteriological Institute has been established as Buda-Pesth, under the direction of Dr. O. Pertik.

All the medical schools have begun work, and the number of students is large.

The post-graduate courses will be given at the Johns Hopkins Hospital as was done last year.

Dr. John Morris of Baltimore, read a paper on the Treatment of Confirmed Drunkards, at the National Prison Association Congress last Tuesday.

A Clinic of Mental Diseases, under the direction of Professor X. Francotte, has been established in the University of Liège.

Influenza of very malignant type is said to be extensively prevalent in Japan. In Tokio alone 100,000 are said to have occurred.

The Chicago Academy of Medicine is the name of a new medical society recently organized and incorporated.

According to Pfitzner, the little toe of man is degenerating. In thirty-six per cent. of the cases he has observed it had only two instead of three phalanges.

On August 11th, a memorial bust of the great French chemist, Gay-Lussac, from the chisel of Aimé Millet, was unveiled at Limoges.

The Association of German Naturalists and Physicians has been invited by the Chief Magistrate of Frankfort-on-the-Main to hold its next annual meeting in that city.

M'lle Everaert has been appointed Assistant-Physician to the Hôpital S. Jean in Brussels. This is the very first female staff appointed in any Brussels hospital.

An asylum for youths suffering from pellagra was opened at Inzago in the province of Milan on September 1st. Dr. Giuseppe Friz has been appointed physician to the institution.

On January 1st the number of students in the recently established University of Tomsk in Siberia was 190, of whom 69 belonged to Siberia and 121 to European Russia. All the laboratories and workrooms are now fully equipped.

Dr. Paul Ehrlich, one of the most distinguished of the younger generation of German workers in the field of scientific medicine, has been appointed an Extraordinary Professor in the University of Berlin.

Miss Ann Frances Piercy, a student at the London School of Medicine for Women, has gained triple examination honors and two gold medals. In *materia medica* she held first place, with a medal, in anatomy, second place, with a medal;

and in physiology and histology she was first-class.

The chair of medical practice in the Rush Medical College, Chicago, made vacant by the death of Professor J. Adams Allen, is said to have been offered to Dr. Henry M. Lyman, formerly professor of chemistry and of diseases of the nervous system in the same institution. Dr. Harold N. Moyer has been elected to the professorship of physiology.

The University Hospital has been thoroughly refurnished and remodeled. The private rooms and nurse's rooms are furnished with steam heat, electric bells, parquet flooring and new modern furniture. A new operating room and an isolating ward has been built. The number of students is unusually large.

Cardinal Manning, not long since, was presented by his friends with an illuminated address and a purse of \$37,000, in token of the silver anniversary of his episcopacy, and he soon afterward made public his intention to devote a large portion of the money-gift to the endowment of a bed in the accident ward of the London Hospital, for the use, *in perpetuo*, of humble workingmen who may be injured on or along the River Thames.

The *Medical Record* says:—Dr. Grace Danforth has reported a case in which a child was the exact image of a gentleman who sat opposite the mother at meal-time, and was not her husband. There was no question of paternity, the doctor thought, neither was there any reason to believe the woman harbored any feeling toward her vis-à-vis which she would not have been perfectly willing to acknowledge to her husband. The young man was red-headed and freckled. This has its parallel in the young white woman, who unexpectedly ran into a very black negro at a friend's house, and who, several years later, gave birth to a negro child.

MARYLAND MEDICAL JOURNAL.

VOL. XXIII. No. 24. BALTIMORE, OCTOBER 11, 1890.

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BY E. TRACY BISHOP, M. D.,
OF SMITHSBURGH MD.

The existing relation of the physician to his patron in the light of the present knowledge of medicine is open to serious criticism. It is the result of the era of specific remedies and of the days of belief in the existence of a fountain of perennial youth. Of the time when Ponce de Leon explored the shores of the flowery peninsula. This doctrine of specifics is older than the war between the authors of *contraria-contrariis* and *similia-similibus*, and is of the time

when it was taught that a clean incision would not heal safely unless it was first cauterized, so as to give opportunity for specific poulticing, and when the object inflicting the wound was anointed with a specific ointment and hung high in the chimney place. It was the time when health was supposed to depend upon a certain chemical condition of the blood, when the lancet swam high on the wave of popularity and gore, when alcohol gave its *essentiæ vitæ* to the thin blood of the victim of phlebotomy, when calomel drove out bile and evil humors. In those days the physician in ominous gown appeared at the bedside, ordered the patient to put out his tongue and felt his pulse, and prepared his remedies according to the appearance of the one, and the stroke of the other. Disease then had no mysteries that could make the doctor doubt or hesitate. The ancient authorities told him what to do, and he did it unflinchingly and unhesitatingly. The modern physician still

*Read before the Washington County Medical Society, August 13, 1890.

investigates the tongue, still counts the pulse, still never fails to prescribe with specific intent, although his examination goes much farther. He now measures the force and records the frequency of the pulse, he takes thermometrical account of the temperature of the body, he makes chemical and physiological tests of the secretions, he takes account of atmospheric conditions and foods, he employs aseptic remedies, in fact all germicidal treatment, including precautions against contagion and infection. This is by far the most important duty the modern doctor performed for his patients, and is the greatest, as it is the most certain of all physiological discoveries. It is no longer a "theory, but a condition that confronts us." There is no doubt, there can be no doubt about it; it is in harmony with a universal law of nature, one organism is ever the prey of another. "Big fleas have little fleas, and these have lesser fleas that bite 'em, and so on ad infinitum." But we must not go too far and take for granted that there is no disease or abnormal condition of system excepting that produced by germ invasion. Then too, are we quite sure that a disease ordinarily of germ origin is always so caused? Pneumonia for example: it seems certain that pneumonia has its concomitant germ, but are there not other causes for the filling up of the lung tissue? The nerve influence, for instance, that sends the blood to the lung, and the other that orders its distribution, are they always in harmony? Suppose that one should send a large current of blood to the lung, and the other should fail to recall it, would we not have a congestion of that tissue? And why could it not happen in meningitis? A very interesting case occurred in this vicinity a few years ago; associated with the pulmonary congestion was a precisely similar condition of the abraded cuticle about the lips. How about valvular obstruction to the flow of blood from the lungs? We take the condition of intussusception. How is that caused? Is it because of want of co-op-

eration of different sections of the intestinal tract? A death from intussusception occurred in the drug store opposite here a few years ago. A boy in apparent good health stooped very low and drank from a pool of water in the road. The unwonted position and act apparently surprised one section of the intestinal tract into muscular action, and paralyzed the other. Was this condition due to the fact that different parts of the intestinal tube are subject to relatively independent motor influences? If so, whence does this influence emanate? Have the various nerve ganglia a separate power as nerve centers subordinate to the brain proper? Physiological research has never yet discovered, or perhaps fairly considered the relation of these ganglia to the great nerve center, the brain, or their relation to the various organs, and yet whole divisions of that animal life of which we are merely a higher type, have no other brain than chains of these same ganglia distributed through their bodies, and they exhibit a good deal of intelligence. I had almost said human, too. Perhaps here is where hypnotic suggestion gets control.

As for the drugs we employ medicinally, it is true that they produce certain toxic or other effects that we can turn to account in the treatment of the sick. Opium and chloroform, atropia, sulfonal and antipyrine and all that, but we must not take for granted that a drug that has a specific effect is a specific cure for a certain disease, or that it has no other systemic effect than that we wish to procure. Indeed we know positively that all these drugs have other and undesirable effects. Furthermore, we have no right to conclude that an abnormal condition of system is always a disease to be tinkered with. For instance, when the thermometer marks one hundred, and the pulse counts ninety, and respiration twenty-eight to the minute, is it absolutely necessary to attack the system with antipyrine? Such a condition will follow an extensive burn, or the large destruction of tissue by an acid.

Local treatment will relieve all the disturbance. Is it necessary then to clutch the heart to restrain it from beating, or to antifebrinize the system to the extent of cyanosis? When we see a patient all convulsed and vomiting, become pale, and apparently lifeless, that condition is as abnormal as the other, but it is a healthy one physiologically speaking, for if we run forward and stand him up we destroy him. Are purgatives always indicated in costiveness? Is it right always to goad the kidneys to action just because we know how? Is the liver always and forever to be stirred up like the lion in the menagerie for the amusement of the party who pays to see the show? In short, gentlemen, is that what we are here for? Can't we do better for our patients than to eternally drug them? The title doctor means teacher. Is it not the highest duty of the physician first and always, to teach his patient under all circumstances how to live to get well? Is not the shortest way to health over the route staked out by the physiological engineer? Is it not a fact that the man who gets well of an attack of disease is less liable to a return of it, than he who has been cured? Are there not diseases that it is not just to treat medicinally or wise to attempt to cure? Rheumatism, a result of peculiar physical condition, or climate, or location, or all of these. Is there any remedy equal to its cure? Ought we not to teach such a patient where to live and how to live to get well? Is it not stupid or dishonest, or both to engage to cure him? Is not the proper treatment of asthma the sending of its victim beyond the reach of the irritant germ? Does not every consideration urge great care in the administration of drugs especially those of great potency? It is an easy matter, as you may have experienced, to so interfere with nature's recuperative resources as to prevent a patient from recovering. A shrewd friend said he did not mind a man's not knowing, but he had no use for him when he didn't know that he doesn't know.

Happily, medical knowledge has arrived at that state that it knows what it doesn't know. Let the medical profession act honestly according to that knowledge. When we do not know what to do let us do nothing. We still have the *vis medicatrix*, the strong right arm, of nature to lean upon. Give the patient perfect sanitation and use no drugs at all. Teach him the great hope there is in nature and the wonderful recuperative powers in his own system. I was present on one occasion when the late Professor N. R. Smith was exhibiting to the class a case of compound fracture of both thighs from gun shot wound treated by absolute rest, which injury had hitherto been invariably treated by amputation. He said gentlemen, we take to ourselves great credit for letting this patient get well. But what would be the result of this conservatism? For the conscientious doctor it would be bad for awhile. His patrons could not appreciate his services. It would be like the lawyer's client who swapped a load of hay for five minutes talk. Unfortunately for us, ignorance among the laity concerning matters of such vital, literally vital, importance is wide-spread and profound, and it seems to me that the higher in the scale of intelligence, otherwise the more profound the ignorance in regard to physiology.

One of the citizens of this town who stood first in every other relation in life, in knowledge and culture, was guilty of the ridiculous absurdity of wrapping wet rags about the legs in an effort to cure a paralysis of the parts. To tell such persons that they can get well of a disease without pill or potion is to send them to the professional wolf. But although your patient can not yet understand that there is such a thing as mechanism in his anatomy, and is still firm in the belief that he is a mere mass of matter "dust of the earth" operated by an all prevading ghost, you may make him understand that you are the servant of nature and merely assist her by removing obstacles and furnishing facilities.

The most important relation of patient

and physician is thorough confidence, whether merited or not, confidence in your abilities in your sympathies in your honesty. It is true that the largest number of patients can be attracted to you by brags and bluster. But that is quackery, with which association and relation of any kind is revolting to the true physician. Use every opportunity to enlighten your patron. Employ remedies as a secondary and undesirable resource and you elevate the calling and eliminate professional parasites. To a popular intelligence, understand the germ causes of disease and nature's resources, what meaning will there be in homœopathy or what demand will there be for patent nostrums?

As to remuneration, as the practice of physic becomes more enlightened, it also becomes more difficult.

The germ cause or mechanical cause of disease and all the conditions resulting from heredity have to be considered.

The surroundings: air, water, elevation to be inspected, food to be analyzed, the time and service to be devoted to a patient will be greater than ever before and of course the compensation will have to correspond. As to uniformity in charges, it seems to be impossible to fix a common rate. The knowledge and skill of one physician will be so much greater than that of another that it will be unjust for the same service to obtain the same reward.

The relation of the medical fraternity is amusing in all its phases and incomprehensible. Take for instance the expert testimony of the physician. He is ordered into court, commonly called a court of justice, and is there made to give an opinion worth anywhere from five to one hundred dollars and his compensation is the same as that of an eyewitness. And if you refuse to surrender your opinion, it is contempt of court, and you are fined or sent to jail for holding your property for fair and just compensation. Will justice always pose as low comedy? I suspect it always will, for law is said to be based upon precedent and it is naturally difficult to go

ahead while eternally looking backward, notwithstanding Edward Bellamy. Another curious thing, in the course of professional investigation, medical men have discovered methods of preventing diseases of various kinds, and their spread, resulting in inestimable good to mankind, adding to the sum of human happiness, and very decidedly increasing the average of longevity. Did the profession try to get compensation for all this or to get a corner in it? Not at all. They urged the prompt employment of all the newly discovered methods and besieged legislatures for the proper enforcement of laws. A profession dependent upon the cure of the sick for its support, enthusiastically eager in its efforts to prevent it. But gentlemen of the profession are you going to continue your ward over the public health? If you are, and I "see no shadow of parting from it," let me call your attention to some things that seem to have escaped the public eye. Let me name a few. The universal use of sugar for instance. What will result or rather what is resulting from it? Fifty years ago sugar was a luxury. Candy! what a rarity. Taffy, excepting the social kind, almost unheard of. Once so rare, now it is the cheap food of the day. Molasses is the poor man's cow. Once the salivary glands were relied upon to supply sugar to the system, now we have no use for them excepting the manufacture of tobacco juice. What will the liver do with all this sugar? How will the kidneys escape it? Is there any relation between Bright's disease, so called, and the excessive consumption of sugar?

Then, gentlemen (excuse the allusion), have you been as eloquent and earnest as usual in explaining to this great lubberly, easy going silly public the effects on the individual and the race of tobacco as a popular and general intoxicant? Have you told them how it bothered you in diagnosis and hindered you in treatment? And then, you representatives of the noblest calling on earth, I except none, have you borne

yourselves according to the custom of "ye ancient days" in regard to that other human blunder, aye, and professional blunder, for it was the medical profession that taught the use of alcohol. Not its use only but its abuse. It was not only prescribed to cure disease. Doctors then thought and taught that it possessed the essence of life itself, one old authority declaring enthusiastically that if one could only take enough of it he might live forever. When we remember that the medical profession is to blame for the common use of alcohol, and we consider the reputation for protecting society against all manner of physical evil they should be doubly vigilant and earnest against this the most destructive and deteriorating of all the assailants of humanity. Then there are yet other social problems, food adulterations and food supplies. These are matters of vital, literally vital, importance to the public, and to the consideration of which its past record has committed the profession. There is still another problem, how to prevent race deterioration by the introduction of foreign blood, but we will not think of it. It might be undemocratic or antirepublican, and we doctors are as great sticklers for party as a bench of supreme court judges. Besides we are doing something, for although we welcome as ruler the whiskey drinking Irish, and as brothers the beer guzzling Dutch, and English, we keep out the opium smoking Chinese.

And how does this appreciating public whom we so faithfully serve propose that we shall be rewarded? Why, as virtue is. That, you know, is its own reward. But it has no purchasing value in any of this world's marts.

The sanitary authorities of Chersson, a town in Southern Russia, recently instituted an examination of the local fruit syrups, which showed that almost all the preparations sold under that name were artificial products, coloured with various matters, such as fuchsin, etc.

FOREIGN BODIES IN THE NASAL PASSAGES.*

BY C. W. RICHARDSON, M. D.,
OF WASHINGTON, D. C.

Several weeks past while having under advisement the most suitable subject for your consideration, this evening, I was in doubt as to which of several to make the topic of this paper. I was actuated in choosing that of foreign bodies on account of its equal interest to the general practitioner and the specialist.

Foreign bodies found in the anterior part of the nasal passages are usually therein introduced by children, hysterical women, the feeble minded and the insane. Unless these bodies on account of size, shape or structure cause painful sensations, they are rarely immediately recognized, as fear on the part of the offender prevents him giving information to parents or guardians. In the adult bodies occasionally find entrance into the nasal cavity as result of accident, and into the posterior nasal cavity during the act of vomiting. The physical characteristics of these bodies are dependent only upon their accessibility and size. What peculiar perversity of character causes the youthful mind to select its nasal passages as a pouch wherein to stow its treasures, we leave for the metaphysician to decide. Small rounded and oval shaped objects, such as, peas, beans, beads, buttons and pebbles are those for which the youngster shows a special predilection. Rough, irregular and pointed bodies are rarely selected. Small pieces of absorbent cotton, used as tampons, and articles of food are occasionally found, the former remaining as the result of neglect, the latter gaining access during the act of vomiting.

The symptoms produced by the existence of such a condition are dependant upon the stage at which the case is seen. In many cases, as a result of the object having remained in situ for many months

*Read before the Clinico-Pathological Society of Washington D. C., June, 17th, 1890.

or years, the mucous surfaces become accustomed to its presence, and does not present those active changes or acute symptoms usually observed immediately following its introduction. In other cases, observed principally in adults, and in children where urgent symptoms usually of a painful character are produced, we see the case in its incipiency; here we have all the symptoms characterizing a severe unilateral coryza, possibly the additional history of the introduction of the foreign body. There is difficult nasal respiration, partial or complete obstruction of the nasal channels, an acid, watery or muco-purulent discharge, headache, neuralgia and injection of the conjunctiva of the affected side. Examination with reflected light will reveal something abnormal lodged just within the nasal cavity, resting against and held in position by the congested anterior extremity of the inferior turbinate. In some few cases the body will have been inserted deeply within the nasal fossæ, and, on account of the swelling of the soft tissues, escape detection by direct inspection; here the mucous surface will be succulent, deep angry red, in color, and nearly or completely filling out the lumen of the canal. There is noted quite an excessive acid watery, muco-purulent or sanguinolent fluid. The use of the probe, with the aid of cocaine will, when the object is not in view, aid in the diagnosis of the condition.

When the body has remained *in situ* for some time, all symptoms due to its immediate presence will have subsided. Under these circumstances the patient is brought to us in order to obtain relief from a supposed nasal catarrh. In these cases we will not obtain any evidence as to the introduction of a foreign body, as the patient will either have forgotten them, or willfully refuse such information. They complain of nasal obstruction, unilateral purulent discharge, loss of sense of smell, headache, asthma and other evidences of reflex nasal irritation. The occurrence of a unilateral purulent discharge from the nasal passage of a

child should always excite the suspicion of the possible existence of a foreign body within the affected cavity. Examination by the anterior rhinoscope will usually, as in the acute case, reveal the foreign body lodged just within the nasal fossa. In other cases the mucous surface will be noted to be greatly swollen, covered here and there with flocculent masses of cheesy pus. After cleansing the cavity, the foreign body, or something abnormal, will be observed hidden between the septum and turgescent turbinate tissue, or folds of mucous membrane.

One's suspicion having been aroused as to the possible existence of a foreign body, its presence not having been assured by simple inspection, it remains to bring to our assistance the agents so useful in diagnostinating abnormal condition of the nasal passages, viz.: cocaine and the nasal probe. Before resorting to the use of cocaine, it is well to thoroughly cleanse the nasal cavity by the use of a good cleansing solution.

Through the agency of cocaine we not only render the mucous surface insensible to the use of the probe, but through its contractile action, exerted upon the turgescent turbinates, obtain a more extensive view of the nasal fossæ. By the use of the probe, we gain not only positive information as to the existence of a foreign something, but also information as to its probable nature, and some idea as to which method will be most expedient in effecting its removal. The body on removal, may present the same physical appearances as when introduced, or it may have undergone various changes, due to the length of time it has remained within the nasal cavity, and to its physical properties. Vegetable objects frequently swell as a result of the imbibition of moisture, and show signs of germinating. Objects obtained from the mineral and animal world, and manufactured substance, frequently show the corroding effects of the acid nasal secretions.

The differentiation of this condition from disease of the accessory sinus, espe-

cially the maxillary, is rendered easy when one remembers that in these affections there is usually no stenosis, and that they occur in adult life. There is also wanting the physical signs of disease of the antrum. Syphilis is usually bilateral, and other evidences of general infection are manifest. Malignant growths not only occur in adult life, but are quite rare and of rapid growth, bleed profusely, and on inspection show the physical signs of malignancy. In summing up I shall give three illustrative cases, each of which presents points of interest.

Several months past, a young boy of five years of age was brought to me for the purpose of examining the nasal cavity. The paternal parent was very skeptical as to anything of a serious nature affecting the child and only brought him to me in order to allay the mother's anxiety. The child had been under the care, for the past two years, of a neighboring practitioner, who had prescribed various sprays for a supposed nasal catarrh. No rhinoscopic examination had even been made. The parents state that the child had considerable nasal obstruction, complete upon the left side; slight nasal discharge; was a mouth breather and snored during sleep. These symptoms had persisted for over two years. In the left nasal cavity, just within the vestibule, was observed a large grayish-black mass which, upon touching with the probe, gave a rough grating sensation. I immediately diagnosed a foreign body, and, within a few seconds removed, with great ease, the large shoe button I now show you. It is almost impossible to conceive how anyone could overlook such a simple case as this. An interesting point in connection with this case, was the almost complete absence of any catarrhal secretion. There was no moisture when I saw the child, and the parents assured me that such was the usual condition.

My second case was enjoying the luxuries of the table, and while in the act

of masticating a piece of beef, was seized with a desire to sneeze. Unfortunately, he attempted to swallow the unmasticated bolus of food before the act of sneezing asserted itself but he miscalculated and the piece of beef instead of passing onward into the stomach, was quite forcibly thrown into the inferior meatus of the left nasal cavity. Upon examination by anterior rhinoscopy, it was impossible to detect anything abnormal; the turbinates were in contact with septum and quite succulent. While waiting for the action of cocaine, I examined the post-nasal cavity, and there observed a grayish-red body wedged in between the inferior turbinate septum and floor of nasal cavity. Three methods of removal were suggested, viz: the removal with post-nasal forceps, the forcing of the body onward into pharynx with index finger in mouth to support its possible entrance into larynx, and the third method, which I adopted, and shall describe. My patient was nervous, greatly agitated and fearful of pain. The first method was not only unfeasible, but impracticable, as the patient could not endure prolonged instrumentation, and the body was too much within nasal cavity to be grasped, except under guidance of the mirror. He would not listen to the second method being employed, as he had been already nauseated several times by overzealous, if not unjudiciously employed index fingers. As a compromise I concluded to adopt the following, viz: placing the patient in a recumbent position, head thrown well back, the nasal cavity being well anaesthetized by the cocaine previously instilled, I instructed him that at a given sign he should make the unpleasant but effectual effort by which mucus is drawn from posterior portion of nasal cavity into the pharynx, then passing an ordinary Eustachian catheter along the inferior meatus until I felt the resistance of the foreign body when simultaneous with the forcing of it onward into pharynx, I gave the signal, and in a moment my patient had drawn

the objectionable body into his mouth, from whence it was ejected.

The third case which I will narrate, is an amusing incident when a pathological entity, existing in the nasal cavity, becoming displaced caused symptoms simulating those of a foreign body. The patient was an excitable medical confrère, whose left nasal cavity was filled with mucous polypi of very large size. He had been in the habit of using cocaine, introduced upon a pledget of absorbent cotton to cause contraction of the tissues and thus make the cavity patulous. On the evening in question he introduced the usual pledget of absorbent cotton and fell asleep. On awaking he felt what he supposed to be the cotton in the pharynx and in consternation rushed for me, that I might remove it, and thus prevent his possible strangulation. Examination showed this large polypus, possessing this long pedicle, dangling over the enlarged inferior turbinate into the pharynx. Quieting his fears I sent him home, exacting the promise that he should call in the morning and have the growth removed. The use of cocaine causing contraction of soft tissues, the recumbent posture favoring, and long pedicle permitting, the polypus had fallen into the pharynx, whereas the secondary relation having occurred before the patient had assumed the erect, the growth was prevented from falling back into its normal position.

Treatment:—In the removal of these bodies the advisability of resorting to local or general anaesthesia, depends largely upon the age of the patient, and to a slight extent upon the nature and position of the body. In very young patients it is more preferable to resort to the general anaesthesia. In older children and adults, local anaesthesia is usually all that is necessary. It is wise to gain as much information as possible as to position, size and possible nature of entity, by the use of cocaine and probe, before any attempts at extraction are made. It will be found that the most expedient method of removal, when the body is sit-

uated in the anterior two-thirds of the cavity, is through the aid of rat tooth forceps or the cold snare. When the body is situated posteriorly I think the method employed in the second case narrated above, will be quite efficient. When bodies are too large for removal through the anterior nasal passages, due to their swelling or the deposition of saliva products about them, it will be necessary to crush and then remove them by ‘piece meat’. When the bodies are very dense and can not be crushed, it will be necessary to resort to Roeyé’s operation in order to gain additional space. Various contrivances have been adopted and devised, but they are seldom at hand when needed and of little value when at hand. Bodies that can be removed by the doubtful methods of exciting sneezing, the douche, etc., can be more readily and satisfactorily extracted by one of the methods indicated above.

1106 L Street.

A NEW METHOD OF DELIVERING THE FETAL HEAD.*

BY BENJAMIN T. SHIMWELL, M. D.,
OF PHILADELPHIA.

Nature’s manner of delivering the foetal head has been followed by obstetricians from time immemorial; recognizing the fact that the occiput is born under the symphysis pubis in normal labor. The face and chin stretch the perineal body, then force their way out, requiring an especial amount of care to prevent tearing of this tissue. The extent of injury to the pelvic floor is not properly appreciated; if the superficial tissue of the perineum is safe the attendant congratulates himself on his possible skill; or if aware of deeper injury, feels grateful that no apparent injury is shown to the watchful eyes of the nurse or patient’s friends.

Thus do thousands get out of the con-

*Read before the Philadelphia County Medical Society, September 10th, 1890.

finement-bed ruined in health, carrying into the future injuries that must of necessity bring ill results. Various plans have been suggested to support and accommodate the perineal body to the oncoming head.

It is strange how often the anatomical construction of the perineum is overlooked and considered merely as a space-filler. It is by this that so much injury is done. The gynecologist's specialty lives by these results.

These are the reasons, hastened probably by experience gained in the above manner, that has induced me to write this paper. The theory that will be advanced, backed by my application of it in a great number of cases, is evidently new; if not, it has not come to my knowledge by reading or otherwise. The advantage of this method is the saving of the pelvic floor from injury either superficial or deep. No attempt is made to show expedition, but a modification of the ordinary method of labor changing the direction of the impinging force.

Naegele says that 70 out of every 100 vertex presentations are in the first position, the other 30 are occiput to right and posterior. The remaining positions are exceedingly rare.

When the head presents in the first position the body of the child must not be overlooked. The back of the child must present to the front and left, the chest to the back and right; therefore at right angles with the vertex presentation of the head at the superior strait. The important point in this theory is the rotation of the head to the symphysis pubis. The manner of rotation of the head is mooted. Pajot claims that the shoulders participate in the rotation, but contradicts himself when he further says: "That it is above all the child's head which decides the character of the movement," also, "That the occiput will, therefore, be carried forward less on account of the direction of the forces which impel it, than because of the necessity, or accommodation of the

cephalic surfaces to the pelvic surfaces." All writers admit that after expulsion of the head occurs restitution takes place, that in a case of first position, after the head is delivered, the head turns with its occiput to the left thigh—that is, in the direction that the head presents at the superior strait; this is an untwisting of the neck.

Gerdy claims that this is "an external expression of the movement of the shoulders within the pelvis, by which the biacromial diameter passes from the transverse to the antero-posterior diameter, the head following the internal rotation." The folly of this assertion is on its surface. The head is free and the neck and body are constricted by the vagina and uterus, and if rotation does take place, can we overlook the anatomical relation and action of the atlas vertebrae? Would not the weight of the head allow of the rotation internal without its external manifestation?

Penrose (Hirst, vol. i. p. 571) says: "While the head has rotated, the body of the child, still in the cavity of the uterus, has been tightly grasped by the firmly contracting walls of the uterus, and has not participated in the movements of the head; hence the shoulders are still oblique at the superior strait, consequently the neck of the child is twisted." The latter theory, according to my experience, is the true one. The fact of the anatomical construction of the cervical vertebrae of the child cannot be overlooked. This arrangement allows of a rotation of one-fourth of its circumference to take place without injury to the spinal cord. Therefore, if Pajot's theory of the accommodation of the cephalic surfaces to the pelvic surfaces, rather than the application of the force, is true, then it can be seen that rotation of the head is possible without the shoulders. Then, again, the head is not free to wobble around the pelvis when it has reached such a condition of flexion, neither is the neck a rigid body depending on the shoulders for its position. If the theory of shoulder rotation

is so, then nature's method is superfluous; for why should the bi-acromial diameter be changed from its oblique position, which is nearer the antero-posterior diameter, to the transverse, then rotate back again beyond its former position to the antero-posterior.

Playfair believes in partial rotation.

Believing, then, that the shoulders still maintain their oblique position through all the stages of the delivery of the head, what occurs when rotation brings the occiput directly antero-posterior? This has been accomplished by the rotation mentioned of the atlas on the axis vertebræ to one-fourth of its circumference; this having occurred, the delivery of the head takes place, then immediately external rotation or restitution occurs, that is, the neck untwists.

The outlet of the female pelvis is four inches antero-posterior and transverse. The antero-posterior is possibly increased a half inch by extension of the coccyx. These measurements are decreased by the soft tissues; this is more marked in the antero-posterior by the rectum and perineal body. As the head in the last act of delivery begins to extend, we have presenting the cervico-frontal diameter, which is four inches; this has to pass through a space that is but four inches; possibly four and a half inches, lessened by the perineal body, which is at this stage excessively stretched and attenuated. As the safety of the perineum is an exceedingly important matter, it occurred to me that this might be accomplished by lessening the size of the impinging body and transferring the extending head into another direction. It is the nose and chin that rupture the pelvic floor, therefore if the direction of this force can be changed to some other point than the junction of the levator ani muscle, it can be easily seen how injury to this muscle can be prevented.

When the labor has reached this stage, I place the woman across the bed on her back, knees well drawn up, then compel her to breath with the mouth wide open to prevent bearing down. As the head

presents in the oblique direction and to reach the antero-posterior diameter it rotates, twisting the neck, the first step in the method is to reëstablish the direction of the first impingement; this is not done until the cervico-frontal diameter is reached; *this must be complete*, then forcing the head into extreme flexion by grasping the presenting occiput by the hand (in non-instrumental labors), I begin my rotation; the first step is to untwist the neck; this accomplished, the head presents cervico-frontal to the left anterior. I then take advantage of the same anatomical construction of the cervical vertebrae that allows of the normal rotation, and rotate one-fourth in the opposite direction, that is, to the left. The cervico-frontal is then transverse, the neck lying on the labia of the left side, the forehead beginning to engage the soft tissues of the right labia. What is now presenting to the antero-posterior diameter, or, what is more important, to the perineum? The biparietal diameter, which measures three and one-half inches, therefore less tension on the perineum. The possibility of delivering the head in the transverse diameter has been questioned. The articulation of the head to the spinal column is wisely arranged; if no other object than health was intended, it has well served its purpose. The diameters of the extending face are those of a right-angle triangle, the hypotenuse of which is four inches, the perpendicular three inches, the base two and four-fifths inches. The mechanical advantage of this is apparent. If the measurements had been those of a triangle the impossibility of delivery is easily seen, the head could not be born as long as the perineum existed. The sweep of the extending head would be the same at the chin as at the forehead, and the perineum would be torn in every case and in every succeeding labor; but the measurements are those of a right-angle triangle, and of a necessity the chin must recede when complete extension takes place, so when extension is made in the transverse diameter of the inferior

strait the chin does not impinge on the ramus of the ischium.

Having got the head into this position, I begin the last stage of the delivery of the head. The head has been all this time in extreme flexion, then extension is performed, the soft tissues of the labia push aside, and nose follows on forehead, chin on nose; delivery is complete, and the pelvic floor is safe. The head then untwists to its normal position,

Society Reports.

PHILADELPHIA COUNTY MEDICAL SOCIETY.

STATED MEETING HELD SEPT., 10TH, 1890

Dr. Benjamin T. Shimwell read a paper on

A NEW METHOD OF DELIVERING THE FETAL HEAD.

(See page 508.)

Dr. E. E. Montgomery: I think that the members of the Society are greatly indebted to Dr. Shimwell for the graphic presentation of this method of dealing with the delivery of the head and effort to save the perineum. This certainly is a violation of that old principle which has been handed down the ages, that "meddlesome midwifery is bad." When we consider that all progress in obstetrics and every step in advancement has been in violation of this principle, this thought may not be considered an objection to this procedure, which certainly seems to be one which should be serviceable. But, not having had experience myself, I am unable to say more than these few words in commendation of it.

Dr. J. M. Baldy: It seems to me that the remarks of Dr. Montgomery, in regard to meddlesome midwifery are true as regards pathological processes, but not

as regards physiological processes. Certain it is that in almost everything in which we have attempted to interfere with physiological processes, we have found that they have been carried on a great deal better by Nature herself than by any so-called improvement that we have made on her. If Nature had meant that the head should be delivered in the transverse diameter of the outlet, she would have given us some indication of such desire. On the contrary, she has shown us very clearly and distinctly that the head was to be delivered in the antero-posterior diameter. It is probable that the head can be delivered in the transverse diameter, as Dr. Shimwell has pointed out, if all the measurements are of average size; but all of us know perfectly well that it is the exceptional head that we come across, and not the typical head. Many of the heads are large, and the higher we get in the stage of civilization the larger the head. The normal head may go through, but I doubt not that Dr. Shimwell will run across many cases that he will not be able to deliver in the transverse diameter. Unless the head will pass easily, we have here no room for extension of the outlet. It is a fixed quantity bounded by bony walls—the ramus of the ischium on both sides—and there can be no distension. On the contrary, in the natural methods of delivery we have free room for the extension taking place through the perineal body and the soft part of the lower part of the pelvis. Now, it may be that there is danger to the levator ani muscles from over distention, but at the same time I conceive, and it has been my experience, that the danger to these muscles is greater in proportion to the amount of interference we give to the perineum. In other words, we have here a hard body starting from a given point and progressing at a certain angle to a certain point at which it meets a plane of resistance, that plain of resistance being the soft parts of the pelvic floor, and, if you will, principally the levator ani muscles. There is a well-known physical law, that

any body moving in a given direction and meeting with an obstacle, will be deflected at a certain angle. We have this occurring in delivery of the head. The head comes down and meets a resistance, which although not a fixed resistance, is sufficient to cause deflection in the line of least resistance. This line of least resistance is the opening of the vulva. If resistance is given to the head at that point, the head is prevented from bulging through the vulvar orifice, and the *vis a tergo* being still alive, must be spent at some place, and that place is at the point of contact of the head with the pelvic floor. Taking the head, which is bulging the perineum and presenting at the vulva, we hold it back by pressure on the perineum, or by some other method; then we are going to have the greater part of the *vis a tergo* exerted at this one point. These soft tissues of the pelvic floor are capable of yielding to a certain point, and when they come to that point, they are going to give, and there will be a tear of the levator ani muscles and the other tissues involved. This is where, I believe, the vast majority of tears of the perineum come in. All teachers teach that the head should be held back in some way or other, so that the vulvar orifice is not allowed to expand and the head protrude, as Nature intended; and by this misapplied force we bring about the accident we are trying to avoid. I have found in the cases in which I allowed Nature to take her course almost entirely, keeping the fingers from the head and perineum, excepting to make slight pressure and lift the head up against the pubic arch, that they have done better and I have had fewer tears, and those that have taken place have been of a minor degree as compared with those where I tried to prevent injury by supporting the perineum. Any support of the perineum whatever is pernicious. I believe that all the teachers and all the books are at fault in that respect. Nature did not mean to have the head held back and have the whole force spent on

one part, when we have the elasticity of all the soft parts well anchored, so as to yield and to give room for the head to pass. Supporting the perineum prevents the proper stretching of these tissues, and prevents any good they may do in bulging the perineum and forcing the vulvar orifice open.

Dr. Shimwell: I am exceedingly sorry that some of my friends who have used this method successfully have not spoken. Dr. Baldy has raised the objection that a large head could not be born transversely, but the same objection applies to the antero-posterior as well. He overlooks the fact demonstrated by the mathematical figure, that we gain, as the chin is delivered, a fraction over one and a quarter inches. The head is born without impinging on the soft tissues of the pelvis.

I have tried this method successfully for a year and a half, both in primipara and in multipara. I have used it both in cases terminated without instruments and in those where the forceps have been required on account of loss of tone or of the pelvic outlet.

In regard to Nature—Nature is not always a good worker. If so, why should we have a disproportion between the head and the pelvis? The outlet should be made equal to the head. With regard to the increase in the size of the head with advancing civilization, I know that; but is the pelvis unchanged? Is it not rather lessened? Has it not changed its size and shape?

The points advanced are, I think, no argument against the method. It is a safe method; it is an easy method; and the delivery is accomplished with perfect safety to the child and to the mother.

The number of students who have entered the University of Moscow for the semester which has just begun is 820, of whom 148 belong to the Medical Faculty.

MARYLAND MEDICAL JOURNAL*Weekly Journal of Medicine and Surgery,*

WILLIAM B. CANFIELD, A.M., M.D., Editor

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BALTIMORE, OCTOBER 11, 1890.

Editorial.**IMMUNITY FROM DISEASE.**

It is very gratifying to note the attempts made to explain immunity and protection from disease. Investigations were not slow to follow Koch and his school of bacteriologists in studying the various organisms and classifying them. And this study was partly to decide whether they were the cause, result or concomitant of disease. It sometimes looks now as if we were getting near the solution of this mystery, yet it is by no means cleared up. These ptomaines and leucomaines play a very important rôle in this

act. The great difficulty is that bacteriologists are too often resorting to analogy to prove their points, and may, indeed, indulge in flights of fancy.

The theory which has been set up and which some have pretended to prove by facts, is that the organism present in the body sets free a poison or ptomaine which hinder its own life, just as animals produce carbonic acid, which is poisonous to them, or yeast fermentation produces alcohol, which stops the growth of the fungus. Thus the body cells are supposed to contain some substance which repels the second attacks of the organism. Acting on this theory, the inoculation of attenuated virus, as in vaccination, is supposed to prevent attacks of disease.

That there is great room for the charlatan to use his powers was seen in the harvest which Ferran reaped in his inoculation against cholera in Spain several years ago. In this way Koch and others are probably carrying on their inoculation experiments. As yet nothing very definite has been announced, and the experiments have been principally confined to animals; still there is a slender hope that the incipient cases and others not too far advanced may be benefited by this treatment, when it has been further studied.

THE DISEASES OF THE NAILS.

The nails are a very important and neglected part of the epidermic group. A certain number of manicures exist in every city, and their influence is noticed on the hands of the fair sex, but physicians in general and dermatologists in particular seem to know or say very little

about the diseased nail. Such work is left for the chiropodist and manicure. This should not be.

Dr. John V. Shoemaker (*Journal of the American Medical Association*, September 20, 1890), has made a few notes on the nails. One of the principal diseases of the nails to which he calls attention in this article is onychogryphosis, or hypertrophy of the nails.

"This disease consists of an abnormal increase of either, or both, the length or thickness of the nail. It is due to an excessive proliferation of the cells of the root. It may be uniform, affecting the whole nail, or only certain portions. In the form most usually observed the hypertrophy or excessive cell deposits occur principally in the central portion of the toe nail, elevating it there and producing an upward curvature. As a result the edges of the nail are depressed, and forced into the soft structures of the toe, producing more or less irritation and inflammation. In neglected cases the inflammation may lead to very serious consequences, requiring, at times, excision of the entire nail. This form of the disease is generally the result of prolonged pressure, as from tight fitting shoes, and is seldom observed anywhere except in the nails of the toes, especially the big toes. It is sometimes observed on the fingers in persons who from their occupation, or in obedience to fashion, are in the habit of wearing tight gloves. Idiopathic cases sometimes occur as the sequelæ of rheumatism, scarlet fever and other diseases. This is, however, rarely noticed. The treatment of hypertrophy of the nail consists in removing the cause of the disease, and restoring the natural condition of the parts.

No remedies will do any permanent

good if the cause be allowed to continue. If, as is usually the case, the disease is limited principally to the nail of the big toe and the adjacent soft parts, the patient must be ordered to remove the pressure, by either cutting out a piece from his ordinary foot covering, or to discard it for a slipper, until cured. When this is done the edges of the nail will no longer be forced down into the sensitive inflamed flesh, and relief will be given at once. The free edges of the nails should then be trimmed down as close as possible, and a mild sedative and astringent ointment applied to the painful parts. One of the best applications is a 5 per cent. ointment of the oleate of tin, or if there be much inflammation a 10 per cent. ointment of the oleate of lead.

Another excellent application is tannic acid 1 part, bismuth sub-nitrate 1 part, adipis 12 parts. If there be much pain 5 grains of powdered opium should be added to each ounce. In some cases the best results are obtained from applying pure carbolic acid directly to the raw surface. A momentary burning sensation is produced, which is quickly succeeded by entire relief from pain. A solid stick of nitrate of silver may be used to accomplish the same purpose. Another analgesic ointment is composed of salicylic acid 20 grains, ext. belladonna, 10 grains, adipis 1 ounce. In chronic cases, where the surface remains raw for days after the pressure has been removed, reparative action can usually be promptly produced by abandoning the use of ointments and dusting the surface with powdered cinchona bark, or pure tannic acid, or oxide of zinc, or bismuth sub-nitrate. If the nail remains thick, or continues to increase in thickness after the removal of all sources of pressure or irritation, its

surface should be softened by frequent applications of liquor potassæ, and then gently scraped with a knife or abraded by a file until it returns to its natural condition. Nightly applications of salicylic acid ointment or plaster over the nails are also serviceable.

Internal medication is seldom required unless the pain be extremely severe, or there is some constitutional disease present. In the former instance, full doses of morphia are indicated to allay pain and procure sleep. In the latter case, appropriate anti-syphilitic, anti-strumous, anti-rheumatic or other needed remedies should be freely given. If the hypertrophy is due to parasitic infiltration, it may be necessary to destroy or remove the greater portion of the diseased nail surface."

Correspondence.

NEW YORK LETTER.

Editor Maryland Medical Journal:

DEAR SIR:—The heated term with all its mugginess and lethargy we can at last say is a thing of the past, and the medical societies and colleges have taken a new lease of life, and are more than busy getting into line for the hard work of the winter.

Medical circles have been more than ever deserted this summer, on account of the large numbers who went to Europe to attend the International Medical Congress, but there has been no diminution in the usual number of summer medical charities. The University Medical College in addition to a few minor changes in its faculty, announces that it is entering upon the fiftieth year of its work, and it has emphasized this event by determining to keep fully abreast with the times,

and require henceforth an entrance examination. A few years ago, it will be remembered, the Bellevue Hospital Medical College made a similar announcement; but unfortunately this very proper step was found to be too much in advance of the times, and financial reasons compelled its speedy abandonment. It is to be hoped that there has been sufficient real progress in medical education since then to render such a humiliating course wholly unnecessary now. It is gratifying to notice year by year, the stronger tendency towards practical instruction; and the time seems not very far distant when the didactic lecture will not figure very prominently in the medical college curriculum. It does not look as though the Roosevelt Hospital was going to have its handsome new operating theatre as soon as was expected. As this hospital has become one of the prominent teaching institutions, it is a pity that there should be any delay in building this addition to the hospital, which when finished, will embody all of the most modern and approved appliances and conveniences, both for teaching and practising surgery. I understand that the work has been hindered by legal complications regarding this magnificent bequest of Mr. Syms. With this operating theatre completed, and the splendid Vanderbilt Clinic, which last year treated over one hundred thousand patients, at the very doors of the College of Physicians and Surgeons, this school of medicine can easily claim to have unsurpassed facilities for clinical instruction.

The new home of the New York Academy of Medicine was not formally opened on October 2nd., as had been expected; but a stated meeting was held there on that day, and one had an opportunity of seeing some of its beauties. When finished, it will be a meeting place of which the medical profession here may well be proud, and until then, it is hardly fair to criticise it; but the first meeting developed a glaring defect in the acoustic properties of the hall, which it is to be hoped may be rectified without

marring the architectural beauty of of the edifice. A formal opening, with appropriate ceremonies, is expected to take place sometime next month.

The weather has continued so mild, that were it not for the bulletin boards of the colleges and hospitals bristling with notices of operations, clinics, and society meetings, one would scarcely realize that vacation time had passed. The State Medical Association has wisely decided this year to hold its annual meeting in October, instead of September; and this fact, together with the unusually interesting programme already announced, promise to draw together a large and representative audience. It is to meet for the first time in the Mott Memorial Hall, and those who have tenderly watched over the library of the Association through its infancy, now announce with pride, that they have the control of a library of over twelve thousand volumes. This library, which is open daily, and is free to members of the profession, although having a central location, is sufficiently removed from the unpleasant din of the city, to offer many inducements to the searcher into medical lore.

In the recent annual report of our Board of Health, we were told that the death rate for 1889 was 25.13 per thousand, not including still births. At present, the health authorities are in a state of mind over the possible death rate for next year, founded on the recent census figures. If this latest estimate of the population be adopted without further correction, this year, with all the numerous maladies following upon the epidemic of la grippe, is likely to appear with unpleasant prominence upon their next annual report.

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A Vienna midwife was recently sentenced to three months imprisonment for having divided the frænum of the tongue in a newborn infant, with the result that it died of diffuse suppuration of the sub-lingual connective tissue.

Reviews, Books and Pamphlets.

Popular Science Monthly for July, August, September and October, 1890. D. Appleton & Co. \$5.00 a year, 50 cents a number.

Atlantic Monthly for July, August, September and October, 1890. Boston: Houghton, Mifflin Co. \$4.00 a year, 35 cents a number.

Scribner's Magazine for July, August, September and October, 1890. New York: Charles Scribner's Sons. \$3.00 a year, 25 cents a number.

The Cosmopolitan for July, August, September and October, 1890. New York. \$2.50 a year, 25 cents a number.

Magazine of Art for July, August, September and October, 1890. New York: Cassell & Co. \$3.50 a year, 35 cents a number.

Anthrax, the Disease of the Egyptian Plagues. By HENRY WILLIAM BLANC, M. D., of New Orleans. Reprint.

Hypodermic Medication in Diseases of the Eye. By CHARLES J. LUNDY, A. M., M. D., of Detroit. Reprint.

The Relation of Eye-Strain to General Medicine. By GEORGE M. GOULD, M. D., Ophthalmic Surgeon to the Philadelphia Hospital. Reprint.

Typhoid Fever. By V. W. GAYLE, M. D., Kansas City, Mo.

Sketch of the late Dr. J. Edward Turner, the Founder of Inebriate Asylums. By T. D. CROTHERS, M. D., Hartford Conn. Reprint.

The Application of Vocal Culture to the Treatment of Throat and Pulmonary

Affections. By EUGENE L. CRUTCHFIELD, M. D., of Baltimore. Reprint.

A Lesson in Phono-Stenography. By F. O. DETTMAN, Stenographer, New York.

The Hystero-Neuroses with Especial Reference to the Menstrual Hystero-Neurosis of the Stomach. By GEORGE J. ENGLEMANN, M. D., St. Louis Mo. Reprint.

Zur Ichthyol-Rehandlung von Frauenkrankheiten. Von Dr. Reitmann und Dr. Schönauer, Operateuren an der Genannten Klinik. Sonderabdruck aus der Wiener Klinischen Wochenschrift, 1890, Nr. 33. Aus der I Universitäts-Frauenklinik des Hofrathes Prof. Carl von Braun-Fernwald. Wien: 1890, Alfred Hölder.

The Treatment of the Morphine Disease. By J. B. MATTISON, M. D., Home for Habitués, Brooklyn. Reprint.

An Epitome of Tripler's Manual and other Publications on the Examination of Recruits. By CHARLES R. GREENLEAF, Major and Surgeon U. S. A., Washington D. C., William Ballantyne & Son. 1890.

Electricity in Gynæcology. By DRs. A. D. ROCKWELL, A. H. GOELET, E. L. H. McGINNIS, A. H. BUCKMASTER, A. L. SMITH, F. H. MARTIN, G. B. MASSEY, and A. J. C. SKENE. Reprint.

An Experimental Study of Lesions arising from Severe Concussions. By B. A. WATSON, A. M., M. D. Philadelphia: P. Blakiston Son & Co. 1890.

Professional Atmosphere, and Morals on Patents and Secrets vs. Liberal Profession. Addresses delivered before the New York Odontological Society. By HORATIO C. MERRIAM D. M. D., Harvard University Dental School.

Fever, Thermotaxis, and Calorimetry of Malarial Fever. By ISAAC OTT, M. D. Ex-Fellow Biology, Johns Hopkins University, Ex-President American Neurological Association, etc., of Easton: E. D. Vogel, Easton.

Addresses Commemorative of James L. Cabell, delivered at the University of Virginia, July 1, 1890. Published by the Faculty.

Professional Patents. By B. HOLLY SMITH, M. D., D. D. S., Baltimore Md. Reprint.

De la Diathèse Unique Pathogénie-Thérapeutique, par E. VIAL, Membre de la Société de Médecine Pratique de Paris etc.: Paris: A. Delahaye.

Coeliotomy: This, and not Laparotomy is the Proper Greek Synonym of "Abdominal Section," Laparotomy being an incision of the Flank only. By ROBERT P. HARRIS, A. M., M. D. Philadelphia: 1890.

Address in Hygiene. By THOMAS J. MAYS, M. D., of Philadelphia. Reprint. 1890.

A Classification of Intra-Nasal and Naso-Pharyngeal Diseases. By LENNOX BROWNE, F. R. C. S., Ed. Reprint. London: 1890.

What is the Present Medico-Legal Status of the Abdominal Surgeon? By WILLIAM WARREN POTTER, M. D., Buffalo, N. Y. Reprint. New York: William Wood & Co. 1890.

Spinal Surgery. A Report of Eight Cases. By ROBERT ABBÉ, M. D., Surgeon to St. Luke's Hospital, New York; Professor of Surgery, Post-Graduate School, etc. Reprint. 1890.

Recollections of General Grant, with an account of the presentations of the portraits of Generals Grant, Sherman, and Sheridan, at the U. S. Military Acad-

my, West Point. By GEORGE W. CHILDS. Philadelphia: Collin's Printing House. 1890.

1. *Case of Corneal Transplantation from the Rabbit's to the Human Eye. II. A Singular Case of Injury.* By WILLIAM F. SMITH, M. D., Chicago. Reprint. 1890

The Sewerage of Columbus, Ohio Address of Colonel George E. Waring, Jr., at Board of Trade Auditorium, Columbus, O., Monday Evening, June 23, 1890, and Discussion Following.

Identité de la Dengue et de la Grippe-Influenza. Par le docteur JULES ROUVIER, Professeur de Clinique Obstétricale et Gynécologique à la Faculté française de Médecine de Beyrouth, etc. Prix: un franc. Beyrouth (Syrie) Direction de la Revue Internationale de Bibliographie. 1890.

The Four Commencements. Valedictory Address to Graduates. By J. M. BODINE, M. D.

Menstruation and the Removal of Both Ovaries. By GEORGE J. ENGELMANN, A. M., M. D., St. Louis, Mo: Reprint from the Transactions of the Southern Surgical and Gynecological Association, November, 1889.

Choloralamid Hypnotic. 3rd Edition. Published by Lehn & Fink, New York.

An Explanation of the Phenomena of Immunity and Contagion, Based upon the action of Physical and Biological Laws. By J. W. McLaughlin, M. D., Austin, Texas. Reprint. 1890.

Transactions of the American Dermatological Association, at its Thirteenth Annual Meeting held at the Boston Medical Library. Boston Mass., Sept. 17, 18, and 19, 1889.

Proceedings of the First Annual Meeting

of the Tri-State Medical Association of Alabama, Georgia and Tennessee, held in Chattanooga, Tenn. Oct. 15, and 16, 1889.

A few Clinical Cases showing the value of Oxygen Combined with Nitrogen Monoxide in the treatment of Pulmonary and other troubles. By E. C. TITUS, M. D., New York. Reprinted from *The Medical Record*, October 5, 1889.

Proceedings of the Detroit Medical and Library Association 1889.

Transactions of the Medical Society of the State of North Carolina. 36th Annual Report, held at Elizabeth City, April 16, 17, and 18, 1889.

Twenty-Second Annual Report of the New York Orthopaedic Dispensary and Hospital, for the year ending September 3, 1889.

Annual Report of the Health Department of the City of Baltimore, for the year 1889.

Transactions of the Washington Obstetrical and Gynaecological Society. Vol. 2, October 7, 1887.—May 7, 1889.

Report of the Provost of the University of Pennsylvania, for the two years ending October 1, 1889.

Tenth Annual Report of the Thomas Wilson Sanitarium for Children of Baltimore. 1890.

The Brooklyn Health Exhibition. Reprint.

Proceedings and Addresses at a Sanitary Convention, held at Vicksburg, Mich., December 5, and 6, 1889.

Proceedings and Addresses at a Sanitary Convention, held at Pontiac, Mich., October 17 and 18, 1889.

The *Queen* pays all expenses.—*The Queen's* last "Free Trip to Europe" having excited such universal interest, the publishers of that popular magazine offer another and \$200 for expenses to the person sending them the largest list of English words constructed from letters contained in the three words "British North America." Additional prizes consisting of Silver Tea Sets, China Dinner Sets, Gold Watches, French Music Boxes, Portiere Curtains, Silk Dresses, Mantel Clocks, and many other useful and valuable articles will also be awarded in order of merit. A special prize of a Seal skin Jacket to the lady, and a handsome Shetland Pony to girl or boy (delivered free in Canada or United States) sending the largest lists. Everyone sending a list of not less than twenty words will receive a present. Send six U. S. 2c. stamps for complete rules, illustrated catalogue of prizes, and sample number of *The Queen*. Address *The Canadian Queen*, Toronto, Canada.

State Board of Health.

QUARTERLY REPORT OF THE STATE BOARD OF HEALTH.

AN INCREASE OF DEATHS DURING THE SUMMER—GREAT IMPROVEMENTS AT LUTHERVILLE—THE ADULTERATION OF FOOD—THE CARE OF CATTLE IN TRANSIT—BETTER LAWS NEEDED.

At the quarterly meeting of the State Board of Health, the secretary, Dr. Chas. W. Chancellor, read his report, in which he touched upon the increase of mortality from contagious and infectious diseases through the state in the past quarter. Forty-eight deaths from contagious and infectious diseases have been reported from twenty-nine localities outside the city of Baltimore during the quarter just ended. Of these twenty-three were from typhoid fever,

eight from diphtheria, seven from dysentery, three from typho-malarial fever, three from cholera infantum, two from whooping cough.

In nearly every locality where typhoid prevails, its origin can be distinctly traced to filthy surroundings, and especially to the pollution of drinking water. Without a pure soil there can be no pure water, and we thus understand why it is that a population supplied with drinking water from shallow wells and springs is liable to typhoid fever, unless the strictest care is taken to prevent the pollution of the soil.

About the middle of June a child died of diphtheria in Wilmington, Delaware, and upon a certificate furnished by a physician of that city, that the child died of "pneumonia," the corpse was transferred into this state by the P., W. & B. R. R. Company in an ordinary casket, without metal lining or any antiseptic precautions. On the arrival of the body at Conowingo Station, it was immediately removed to the residence of the grandfather, at Prospect, where the coffin was opened and the remains viewed by the family. In a few days thereafter there was an outbreak of diphtheria in the house, and in less than a month six or seven members of the family were attacked, and five died of the disease in a malignant form. It then spread to other families in the neighborhood.

After touching on the need of proper protection of the water supply of Cumberland and Baltimore, and the need of special legislation on this subject, Dr. Chancellor refers to the improvement made in the sanitary conditions of Lutherville, and says: Fully ninety per cent. of the objectionable features noted in the report have been corrected, or are now undergoing improvements, and the place will soon be exceptionally free from insanitary surroundings. With only two exceptions, the pig-pens and closets that lined the banks of Roland Run, and poured their filth continuously into it, have been removed or so constructed as

to be no longer a conspicuous cause of bad odors in the town, or a source of pollution to the stream. Of the fifteen notices served to abate nuisances and to discontinue any act whereby the waters of Lake Roland might be fouled, only one or two individuals, jealous of their domestic right to poison themselves, and "the rest of mankind," if they choose to do so, have failed to comply with the requirements of the notice sent, and proceedings have already been entered against them according to the provisions of the laws of 1890, chapter 622, as advised by the Attorney General.

The work of food and drink inspections has been energetically pushed forward in the city of Baltimore and some of the larger towns of the state. It is contemplated during the ensuing fiscal year to bring, as far as practicable, every portion of the state under the operation of the law, so far as the limited appropriation for the purpose will allow. Thus far, the results accomplished have been exceedingly satisfactory. In every case where proceedings have been entered against parties violating the law the grand jury has found a true bill, and I am informed by the state's attorney that the offenders will be speedily prosecuted.

The cruelty to animals in transit over railroads, and the consequent injury to their flesh, should be a matter of thorough investigation. It is known that cattle are constantly transported from the West to our market not only in cars overcrowded to suffocation and death, but at times are deprived of food, water and rest for days together, and are, moreover, cruelly beaten, prodded and otherwise tortured when they fall from exhaustion or become maddened and fractious from ill-treatment. It is estimated that five per cent. of cattle annually die on the passage to market from the West, and is said that even these are sold in our markets, while the cattle that get through alive, for want of food and water, and by reason of the cruelty inflicted upon them, come out of the cars full of fever, and many with bruises,

sores and ulcers. These are sold to an unscrupulous class of butchers at a mere nominal price, who dress and sell the meat in our markets for human food. Professor Agassiz calls attention to the dangers arising from the ill-treatment of beef cattle before slaughtering them, and it is unquestionably true that the eating of such meat produces disease in those who eat it. What can be done as a remedy in this matter? I would suggest that a bill be drafted and presented at the next session of the legislature compelling railroads delivering cattle in this state to take proper care of the cattle in transit—the same as they are required to do in the case of human passengers—by providing suitable cars and not overcrowding them. If the legislature would take the matter in hand and prevent this cruelty to animals and the barbarous way of rushing them into our market, some dead and others more dead than alive, it would do more to give us healthy food than all the meat inspectors that could be created. The Paddock Meat Inspection bill, recently introduced in Congress, provides for the condemnation of diseased animals or carcasses, but not against the ill-treatment of cattle before they are slaughtered. This is a matter that should be corrected by the respective state legislatures.

After the report was adopted the secretary stated that he had visited quite a number of localities in the state where infectious diseases prevailed or where nuisances were reported, all of which had been abated without resort to law. A complaint numerously signed, had been preferred against a burying ground on Bellona avenue, near Govanstown, which was reported to be in a state of nuisance from overcrowding with dead bodies; but action was deferred, in order that the matter might be considered and disposed of by a full meeting of the board. Attention was also called to a correspondence had with the mayor of Rockville, in reference to a burying-ground in that town. In connection with this subject, the board passed the following resolutions:

"That, to avoid the hygienic dangers incident to grave yard pollution, no dead bodies should be buried in proximity to thickly built-up areas of population, but that all dead bodies should speedily find a resting place in the soil at such a distance from habitations that the putrefactive process of the grave may not exercise its baneful effects upon the living; that the secretary be requested to investigate the matter complained of on Bellona avenue, Govanstown, and confer with the Attorney General as to the proper legal steps to pursue should the sanitary requirements of the case necessitate action on the part of this board."

The secretary submitted a correspondence with Mr. E. F. Perkins, school examiner of Kent county, in reference to the vaccination of school children. The Board approved of the suggestions made on the subject in the letter of the secretary to Mr. Perkins, and passed the following resolutions: "That no person can be considered as duly vaccinated until a record is made up in the case, which record should show the date of the vaccination, whether a primary or a revaccination, and whether successful or unsuccessful; and no physician is justifiable in certifying that a child has been 'duly vaccinated' until such a record is complete, unless there exist unmistakable indications of a previous successful vaccination, performed within a period not longer than seven years; that, in the opinion of this board, the words 'duly vaccinated,' required by the law of the state to be inserted the physician's certificate before a child can be admitted into the schools, implies 'duly protected' and that no child should be admitted into the schools until such a certificate is furnished by the parent or guardian of the child."

Drs. Piper, Roche and Chancellor were appointed a committee to confer with the state health authorities of West Virginia and Washington with reference to securing the passage of an act by the legislature of West Virginia to prevent the pollution of the Potomac river, that

furnishes the water supply of Cumberland and Washington.

Hospital Reports.

THE PRESBYTERIAN EYE, EAR, AND THROAT CHARITY HOSPITAL.

Under the new order for clinic work for the medical students of the University of Maryland, besides the Saturday morning eye clinic at the University of Maryland Hospital, corner of Lombard and Green streets, two clinics are given weekly at the Presbyterian Eye Hospital, 1007 East Baltimore street. Every Tuesday and Thursday are clinic and operating days at this hospital. This gives two didactic, and three eye clinics for the course of eye surgery at the University of Maryland. The abundance of material for the clinics was well shown at the opening eye clinic on Tuesday. The following eye operations were the day's offering from the Free Dispensary:

Restoration of an upper lid, torn off one year since from the explosion of a shot gun,	1.
Enucleation of an eye ball in a child for cancer,	1.
Enucleation of an eye-ball in an adult for injury,	1.
Internal squint in a child for tenotomy,	1.
External squint for muscular section,	1.
Capsular cataract for needle operation,	1.
Iridectomy for closed pupil,	1.
Cyst of the conjunctiva,	1.

Physicians from a distance who are in the habit of sending their poor patients to the Presbyterian Eye, Ear, and Throat of Baltimore for operation, will remember that Tuesday and Thursday are operating days at this charity hospital. Clinical work for eye diseases commences at 2 o'clock each day.

Medical Items.

Dr. George M. Sternberg, U. S. A., has been ordered to San Francisco.

Chicago has one thousand six hundred and twenty-one physicians, including all schools.

The Chicago Health Commissioner objects to leg vaccination. Our Health Commissioner does not oppose it here. This may afford some consolation to our poorly paid vaccine physicians.

It has been determined to postpone the next meeting of the International Congress of Otology, which had been fixed to take place at Florence in September, 1892, till 1893, when it will be held at Rome a week before the assembly of the Eleventh International Medical Congress.

The number of students in the University of Buda-Pesth in the academic year 1889-90 was 3,606, of whom 1,204 belonged to the medical faculty. Besides these there were 228 students of pharmacy, and 73 women attended courses of instruction for mid-wives.

At a meeting of the Clinical Society of Maryland, held Friday, October 3rd, 1890, the following were elected for the ensuing year: President, Dr. Hiram Woods; Vice President, Dr. J. W. Chambers; Secretary, Dr. R. B. Warfield; Corresponding Secretary, Dr. C. O. Miller; Treasurer, Dr. G. A. Fleming; Executive Committee, Drs. W. S. Gardner, V. L. Norwood, and L. F. Ankrim.

The *Medical Record* says: The effort to boom the medical college in connection with Johns Hopkins University by making it co-educational goes merrily on. Despatches state that more than \$60,000 have been raised, mainly in Baltimore, Boston, New York, and Philadelphia, and a committee will soon be organized in Chicago. The trustees have

not yet said whether or not they will admit women to the Hospital school, but the ladies expect their hundred-thousand dollar offer to overcome all objections.

Dr. Lothar Heidenhain, who has been appointed Professor of Surgery at Greifswald, is a nephew and pupil of the late famous surgeon, Richard von Volkmann. His first literary work, entitled "Arthroscopy and Arthrectomy," appeared in 1886, and is a faithful account of Volkmann's views on this branch of surgery. This work has been followed by reports of microscopic investigations of the local reappearance of cancer-tumours after the removal of cancerous mammary glands, observations on the value of chloroform in the preservation of anatomical preparations, &c.

Mr. A. M. Hurlock, attorney at law, 17 St. Paul Street, having had a large experience with physician's claims, and having found that many of such claims are legally uncollectable owing to a defect in our laws, proposes, with the assistance of the profession of this city and State, to have the following Bill passed in the Legislature of Maryland:

WHEREAS, Under the existing laws of this State the property of married women is not liable for medical services rendered to such women, or their children; and

WHEREAS, calls for such medical services are frequently made under circumstances that do not allow the making of inquiries as to the pecuniary condition of the husband and father, and much hardship is thereby caused to those rendering such medical services; therefore,

Section 1. *Be it enacted by the General Assembly of Maryland,* That married women shall be jointly liable with their husband for medical services rendered to such married woman or their children, that they may be sued jointly with their husbands for such services, and that judgments obtained in such suits may be a lien in their separate property.

Sec. 2. *Be it enacted,* That this act shall take effect, &c.

MARYLAND MEDICAL JOURNAL.

VOL. XXIII. No. 25. BALTIMORE, OCTOBER 18, 1890.

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Original Articles.

RIB-FRACTURE FROM MUSCULAR ACTION, WITH FORTY COLLECTED CASES.*

BY JOSEPH P. TUNIS, M. D.,
OF PHILADELPHIA.

As fractured ribs form no inconsiderable part of those fractures which physicians are called upon to treat, some remarks on their rarer etiology may not be out of place. It is the object of this paper to report two recent cases where ribs were fractured, apparently from muscular action alone, and to collect together those which have already been published.

Different views have been expressed on the question, whether a fracture can be caused by muscular action alone, in

*Read before the Philadelphia County Medical Society, September 24, 1890.

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bones not previously diseased. Some have positively denied such a possibility, as Richerand¹, Vidal (de Cassis)², and Hornidge³. Others maintain a non-committal silence, as Petit,⁴ Duverney,⁵ Monteggia,⁶ Desault,⁷ and Bryant.⁸ But the majority of surgical writers admit the possibility of such fracture, as Samuel Cooper,⁹ Nélaton,¹⁰ Malgaigne,¹¹ Purch,¹² Gurlt,¹³ Follin,¹⁴ Marchaud,¹⁵,

1. Nosographie Chirurgicale. Paris, 1815, tome iii. p. 13.
2. Traité de Pathologie ext., 2d ed., tome ii. p. 215.
3. Holme's System of Surgery. Amer. ed., 1881. Art. "Fracture," Vol. i. p. 481.
4. Traité des Maladies des Os. 3d ed., 1736, tome ii, p. II.
5. Traité des Maladies des Os (publie par Senac), 1751. tome i. p. 15.
6. Instit. Chir., Part II., 1808.
7. Œuvres Chirurgicales, 1798 (publie par X. Bichat), tome ii. p. 320.
8. Bryant's Surgery, Amer. ed., 1873, p. 828.
9. Cooper's Surgical Dictionary, S. A. Lane's ed., 1861 vol. i. p. 683.
10. Pathologie Chirurgicale. Paris, 1844, tome i. p. 635.
11. Treatise on Fractures, trans. by Packard, 1859, p. 38.
12. Des Fract. du Clavicle par Action Musculaire. Ann. Cliniques de Montpellier, par A. Alquin, No. 4, Avril, 1857.
13. Handbuch der Knochenbrüchen, Berlin, 1802, vol. i. p. 228-254.
14. Folin et Duplay: Traité class. de Pathologie externe, 1875, tome ii. p. 784.
15. Dict. Encyclop. des Sci. Med., "Fractures" (Pathologie Chirurgicale). Paris, 1881, vol. iv. p. 17,

Erichsen,¹⁶ Agnew,¹⁷ Ashhurst,¹⁸ Hamilton,¹⁹ Gross,²⁰ Packard,²¹ Stimson,²² and others. We have the best authority therefore, for believing that bones have been and will be fractured by muscular action alone, even in persons of good constitution. The elder Gross writes: "A diseased state of the bone is not at all necessary to the production of this accident."²³ Gurlt,²⁴ having collected a large number of the so-called "spontaneous fractures," confirms this view. Simon Paul,²⁵ also, and Professor Stimson in a recent *Treatise on Fractures*.

Moreover, in certain²⁶ instances where an autopsy was possible from some extraneous cause, a careful examination of the bones has demonstrated their healthy condition.

Of the one hundred and thirty-three cases collected by Gurlt, the majority had some condition present which rendered them more easily broken. Any condition which lowers the normal consistency and resistance of the bone structure must predispose to fracture, as osteomalacia,²⁷ rickets,²⁷ cancer,²⁷ syphilis,²⁷ scrofula,²⁷ advanced age (*i. e.*, over fifty),²⁸ or atrophy from continuous confinement,²⁹ etc. "In short, all diseases dependent upon cachexia more or less predispose to the occurrence of fracture," says Hamilton.³⁰ When some such cause is present the existence of a fracture from muscular action can be more readily accounted for. There are, however, numerous cases on record where such accidents have occurred in healthy individuals, the de-

termining cause of fracture being muscular action, and the mechanism varying with the anatomy of the bone affected. If these conditions are true for other bones, why may they not be equally true for the ribs?

The ribs offer three factors favorable to fracture: *First*, by their shape, being long, thin bones; *second*, by their position, firmly attached at the vertebral, and more or less free to move at the sternal end, and *third*, by reason of the powerful muscles attached to their bodies. They are "elastic arches"³¹ it is true, and capable of considerable movement. But their elasticity has its limit, and their movement is dependent entirely upon the muscles attached to them. Of these muscles the diaphragm appears to be the most favorably situated to produce rib-fracture. Centrally attached by its crura and ligaments to the vertebral column, it is connected at its circumference "on either side, to the inner surface of the cartilages and bony portions of the six or seven inferior ribs interdigitating with the transversalis."³² Take, for example, the ninth rib. If the diaphragm should contract, it would draw the anterior third of this bone toward the vertebral column, the other two-thirds being held more or less firmly *in situ* by the serratus magnus, attached posteriorly, the internal oblique, the transversalis, and the intercostals. This contraction of the diaphragm continuing, if sufficiently powerful, would fracture the bone like a bent bow at the point of least resistance. Where the attachment of the serratus magnus left off, would seem a favorable seat for such a fracture. Has the diaphragm sufficient force to accomplish this? It has sufficient force to free the throat or bronchi of irritating material, almost approximating the sternum and the vertebral column in dyspnoea, often demonstrating clearly its power in membranous croup. It can eject forcibly the contents of the stomach on occasion, or cause great distress, and

16. Science and Art of Surgery, Amer. ed., 1869, p. 24.
17. Principles and Practice of Surgery. 1st ed., vol. i. pp. 718 and 852.

18. Principles and Practice of Surgery, 4th ed., 1883, p. 223.

19. Fractures and Dislocations, 5th ed. Philadelphia 1875, p. 30.

20. System of Surgery, ed. 1859, vol. ii. p. 104.

21. International Encyclopedia of Surgery, 1881.

"Causes of Fracture," Fol. iv. p. 3.

22. A Treatise on Fractures, 1883, p. 93.

23. Ibid. 24. Ibid.

25. Des Fractures Spontanées, 1886, Paris, pp. 12 and 13 etc.

26. Herard (Case 2), L'Union Medicale, 1855, p. 459.

27. Principles and Practice of Surgery, Ashhurst, 4th ed., 1883, p. 224.

28. M. Rappey, Traité d'Anat. Descriptive, 3d. ed., 1876, tome i. p. 66.

29. Dict. Practical Surgery, Heath, 1883, Frag. Ossium, vol. i. p. 573.

30. Fractures and Dislocations, 5th ed., 1875, p. 29.

31. Gray's Anatomy, Amer. ed., 1883, p. 220.

32. Gray's Anatomy, new Amer. ed., 1883, p. 220.

even death, from obstinate hiccough. Well supplied with blood, exercised day and night, its actions uncontrolled, we may with some reason believe that, suddenly exerting all its force on three or four ribs, one or more may fracture. Certain it is that the ribs to which the diaphragm is attached are most frequently fractured (almost the only ones), and the circumstances which excite the action of that muscle are most often given as the exciting cause of the accident.

Above the sixth rib, other muscles enter into the mechanism of fracture. In the sixth case which Dr. C. B. Nancrede has reported, and in Dr. Bird's case, where the second rib yielded under unusual muscular strain, the pectoralis minor seems to have been the most probable determining cause, as this muscle³³ is attached to the third, fourth, and fifth ribs, often to the second, and is inserted into the coracoid process of the scapula. If the scapula were firmly held in place by the powerful muscles attached to it, the pectoralis minor would be in a position to act with the advantage of leverage. This muscle, or the serratus magnus,³⁴ would draw the anterior third of the bone away from the vertebral column, directly opposite to the movement of the lower ribs under the action of the diaphragm. Thus the mechanism in the large majority of these cases may be reached. Some still remain which require a special explanation from the facts of the case.

Malgaigne³⁵ was the first to call attention to the possibility of rib-fracture from muscular action. He had collected eight examples, of which he wrote: "I think it very probable that in all these cases the ribs had undergone more or less of the atrophic thinning of which I have before spoken; and that the fracture was induced by muscular action, which in coughing approximates the sternum and the spinal column, just as exterior pressure does." Poulet,³⁶ in his article,

"Ribs," of the Encyclopædia, gave six more examples and mentions five cases where the *costal cartilages* were ruptured by muscular violence.³⁷ Théophile Mazeille, in 1882, brought together twenty-four cases in tabular form.³⁸ Since then, so many additional cases have been reported that they number not at least forty.

The two recent cases here given have not been previously reported:

Mrs. D., fifty-two years old, in March, 1890, came to the Episcopal Hospital Dispensary, seeking relief for a hacking cough and severe pain in the left side. Her emaciated figure, gaunt features, and parchment-like pock-marked skin, gave evidence of long-continued mal-hygiene and mal-nutrition. Her family and personal history were negative, but her broad flat nose, with deep triangular markings running off from it, made us suspect inherited syphilis. For the last three years she had suffered from rheumatism, but could remember no other sickness. Three out of her four children died in childhood. She stated that eleven days previous to her coming to the hospital, while lying on her right side on a lounge, she was suddenly seized with a violent fit of coughing. While coughing she felt a severe knife-like pain in her left side, and at the same instant something snapped "like a little stick." Not thinking that she could fracture a rib in such a manner, a sedative cough mixture was prescribed, and she was directed how to apply a turpentine stupe.

She returned the next day unimproved, and complaining bitterly of the pain in her side. A thorough examination of the chest then showed positive signs of fracture, of the tenth rib on the left side, about its middle. Dr. H. C. Simes, Dr. George Boyd, Dr. W. R. Lincoln, Dr. F. Rudderow and Dr. L. H. Adler, Jr., afterward confirmed the diagnosis. There was no evidence of any direct violence in this case, and the patient gave a very clear account of the accident. Her cough was due to an attack of bronchitis.

³³ Gray's Anatomy, p. 410. ³⁴ Ibid., p. 409.

³⁵ A Treatise on Fractures, translated by Packard, 1859, p. 348.

³⁶ Dict. Encycl. des Sc. Med. Art. Cotes, p. 61. Paris, 1887.

³⁷ Ibid., p. 84.

³⁸ Theses de l' Ecole, No. 263: "Des Fractures de Cotes par Action Musculaire," Paris, 1882, p. 45.

Strapping the affected side brought immediate relief, and she was discharged cured in six weeks.

Dr. Edward Martin has kindly furnished me with the particulars of the following case, which was treated recently at the University Hospital Dispensary:

FRACTURE OF RIB FROM MUSCULAR CONTRACTION. — James C. H., aged twenty-eight (about), a slender-built, muscular man, of healthy parentage, by occupation a laborer. By lifting a heavy beam, together with several workmen, the weight was suddenly thrown entirely upon himself. He was stooping slightly forward at the time, with his fingers grasping the bottom of one end of a beam; he was subjected to a sudden, violent strain. He heard a distinct crack, and felt an acute pain in the left side, as though a knife had been thrust in. The pain was greatly aggravated by breathing or coughing, and he distinctly perceived a sense of grating on motion. On examination, the sixth rib was found fractured at its sternal angle. There was no deformity, no ecchymosis. The patient was strapped, and made an uninterrupted recovery. There was no history of unusual brittleness in the bones of himself or in any member of his family.

For convenience, the collected cases, forty in all, have been divided into three classes.

Class I.—Healthy bones.

Class II.—Diseased bones.

Class III.—Cases with incomplete records.

DEDUCTIONS.

1. Forty cases having been reported, we may reasonably expect to hear of others, perhaps see them ourselves.

2. Of these accidents, more than one-fourth have occurred in individuals of apparently sound constitutions.

3. The left side has been most often affected, and either the middle or anterior third of the rib the usual position of the fracture. Of forty-nine fractures only five have occurred above the sixth

rib. The great majority have been among the lower six (omitting the twelfth).

Rib Affected.

Second rib	.	.	.	2
Fourth "	.	.	.	1
Fifth "	.	.	.	2
Sixth "	.	.	.	5
Seventh "	.	.	.	3
Eighth "	.	.	.	7
Ninth "	.	.	.	7
Tenth "	.	.	.	6
Eleventh rib	.	.	.	7
Unrecorded	.	.	.	9

Side affected.

Right side	.	.	.	10
Left "	.	.	.	19
Unrecorded	.	.	.	11
Total	.	.	.	40

4. The exciting causes have been: Coughing (twenty-five), muscular effort (eleven), sneezing (three), and vomiting (one). The determining cause has been the action of the muscles, unless thirty-four observers have been deceived by the testimony of patients who could gain nothing by such deceptions.

5. Herard reports the youngest example of this accident, a woman, twenty-two years old. No case has been published younger than this—no doubt on account of the great elasticity of the ribs in youth.

6. Of these forty cases, two died of some intercurrent affection. The remaining thirty-eight made a complete recovery in the usual time.

7. More men (twenty-two) have suffered than women (seventeen), and the average age has been forty-eight years.

The difficulty and the doubts which have attended the diagnosis of many of these cases ought to disappear, as more and more examples of this accident are reported. Already, by the consent of the majority of surgeons, and by the evidence of accumulated cases, the possi-

bility of rib fracture from muscular action, even in persons of sound constitution, seems sufficiently proven.

PRESIDENT'S ADDRESS.*

BY H. L. E. JOHNSON, M. D.,
OF WASHINGTON D. C.

Gentlemen:—It is with unfeigned pleasure that I rise to address you upon this occasion, marking as it does the completion of the second year of the active life of the Clinico-Pathological Society. The manner in which the organization has grown and prospered and the permanent basis upon which it stands today, prove that its formation was no visionary experiment, but a practical and sensible conception of the necessities and possibilities of the junior members of the medical profession,

The theory upon which it has been formed is that there existed a hiatus between the new graduate and the established physician in organizational life, which it was difficult to bridge and which constituted an impediment to the successful discussion of those physical problems which are presented to both the new and the old physician alike, in the ordinary course of professional experience and which cannot be considered and discussed upon an equal footing between them, for those obvious reasons of distinction which have their foundation, not so much in inequalities and unamiable characteristics of the profession, as in the inherent defects of human nature. This organization has for its basis the idea of uniting together, upon terms of entire equality, a limited number of the junior members of the medical profession, under a system which insures personal respect, individual congeniality and mutual improvement.

When I call attention to the facts that at its organization, solicitation and argu-

ment was necessary to induce a sufficient number to enter, to give it its initial impetus, and that now the entire limit of its membership is nearly filled, and admissions are sought instead of being offered; when we reflect upon the many able papers which have been read and the useful and beneficial discussions which have taken place at its regular meetings, I think no doubt can be entertained that the conception and execution, the development and perfection of the Clinico-Pathological Society has been an unequalled success.

I shall not attempt to make a resumé of the Society's work since its organization, further than to say it has achieved a position distinctively honorable and creditable among medical societies; that it has drawn to it the best talent of our profession and that it has never experienced a collision or personal unpleasantness among its members nor the first sign of discontent in its organization, the forerunner of disruption.

As one of its original members, more than in my official relation to the Society, I feel privileged to make some suggestions, founded upon my experience as a member, gathered by personal and careful observation and consideration:

First.—It seems to me that it would be expedient to change the day of meeting, as we have oftentimes experienced "short" meetings, or none at all, owing to conflict of time with other societies or undesirable proximity to their days of assembling. I would suggest Thursday as being the least likely day to be obstructed, and would recommend its adoption.

Second.—I think the number of members present, necessary to admit of the reading and discussion of a paper, should be reduced from a quorum to some smaller number, say ten members, as it seems to me unwise to postpone the reading and discussion of a paper which a member has been at some pains to prepare, and at the reading of which others have been at some inconvenience to attend, if a sufficiently respectable num-

*Read before the Clinico-Pathological Society of Washington D. C., June 18th, 1890.

ber be present. As this involves no organizational changes in the Society, and could by no possibility effect, by surprise, undesirable changes, I see no objection to its adoption. In order that this idea may cut both ways and be of equal advantage to all, I would also suggest,

Third:—That in the event of the regular essayist of the evening not being present or not being prepared, the one next on the call be required to be prepared in the nature of an alternate, to read his paper in lieu of the regular essay. The advantages derivable from this change I think would be first, reasonably to assure preparation on the part of the essayist; second, to secure to those in attendance an essay at all events, and third, by creating a possible diversity of subjects to "scatter" or diversify the preparations for discussion by the other members.

In looking back upon the work of the Society, I am mindful of the excellent manner in which, in the main the various duties of the several committees have been discharged, for which I think we should feel ourselves deeply indebted. At the same time I am aware that this work has not been wholly beyond criticism; that of the Committee on Pathology and Microscopy having been susceptible of more energized activity. In this connection I would make a further suggestion, namely:

Fourth:—That those members connected with hospitals have the better opportunities for collecting specimens appropriate and useful to this branch and should endeavor to aid the Society by such collections. If pathological specimens be not attainable, normal specimens have a still more useful office in the junior practitioner.

I can not conclude these informal remarks without some reference to the social element of our organization. I feel particularly grateful for the kind and harmonious support I have received during the past year from each and every member, and I desire particularly to

thank our former and first president for the benefit of his good example and efficient management in the first year as a guide to my own course.

The general good fellowship and kindly feeling which has at all times prevailed, leads me to suggest that as we are under no expenses and could, without individual inconvenience to any of us, well arrange it, it would be a most agreeable addition to our regular order if we should conclude our annual meetings with a banquet at which the mind and the palate might alike be refreshed and our truly normal physiology be the better respected and sustained.

AUTOPSIA CADAVERICA.*

BY JOHN H. KOONS, M. D.,
OF RINGGOLD, MD.

Autopsia cadaverica signifies the examination of the body post-mortem to determine the seat of disease, and cause of death, and is to be distinguished from the doctrine of empiricism, or autopsy as understood by the founders of that ancient school.

The empirics made no investigation as to the cause of disease, but simply confined themselves to such treatment as observation and experience demonstrated to be good. They were utterly ignorant of the physiology or anatomy of the living subject, much less the dead, hence much of their knowledge was based upon superstition, and many of their remedies most ridiculous, for example, they prescribed for epilepsy, the brain of the camel, the rennet of the sea calf, the excrement of the crocodile, and the testicle of the wild boar.

It is over two thousand years ago since that school flourished, and while it discarded pathology, it laid great stress on personal observation and comparison of cases. They studied the living subject alone, we, the living and the dead.

*Read before the Washington County Medical Society June 13th, 1890.

But our observations are far from what they should be, especially upon the dead subject. In large cities where physicians have access to hospitals and are active members of pathological societies, they can acquire a large experience in this branch, but this is not the case with the country practitioner. The physician in the country has fewer opportunities and greater opposition, and much to contend against.

From time immemorial there has been opposition to meddling with the dead human body, especially with any cutting instrument.

The Egyptians were the first to use any cutting instrument, and that was permitted only under the strictest regulations. It was with the greatest dread that they allowed any one to approach the dead body, and even the operator or paraschistis as he was called, after he made the incision for the embalmer, would flee from the spot to protect himself from imprecations and stones at the hands of the people.

They were ignorant of the first principles of anatomy. One of their notions was that the heart increased in weight two drachms every year until the age of fifty, and decreased until death at the same ratio.

In Greece, superstition was so well founded in regard to the sacredness of the dead, that any attempt to interfere with these sacred rights was considered a most heinous crime and punished with death. These prejudices had their source in the opinion of the Greeks that the soul when severed from the body wandered on the banks of the river Styx, until the body was consigned to earth or consumed by fire; hence they buried their dead as soon as possible after death in order to insure rest to the soul. Though it is many centuries since these people lived, yet in this enlightened age of ours we have the same superstition confronting us, and it is only by educating the people that we will ever overcome this senseless and persistent oppo-

sition to autopsies. There is something radically wrong, for my part I cannot understand why people of good sense and judgment deny physicians a privilege which cannot help being a benefit to the family and community, besides advancing science in the interest of mankind. Why, when a man gets sick, does he want an old physician, or to be taken to the city to consult in regard to his health, but for the simple reason that the man he seeks has had experience, never for a moment thinking that the man of experience obtained it by examining the dead bodies of men just like himself.

What was it that made the illustrious Gross to stand at the head of American surgery? Nothing more nor less than his untiring zeal to fathom the mysteries of all morbid conditions to which flesh is heir. As founder of the Philadelphia Pathological Society, he did a great work and always proved his assertions by pathological examples, where such could be obtained, and in every lecture he enjoined upon his students the necessity of such investigation.

The physician should not limit himself to the study of healthy and relative anatomy alone, but should have a thorough knowledge of morbid anatomy. He should know the changes that are brought about by different diseases, and their effect upon the various organs of the body.

If great surgeons will not take up the knife to perform an important operation without first operating upon the cadaver, how much less are we fit for similar work? This does not only apply to surgery, for a man can no more be a good physician than he can be a surgeon, unless he understands the morbid anatomy of the tissues.

The question now arises, why should we be deprived of the opportunity of making such examinations, and what are the means of breaking down this barrier between the physician and the people. One of the greatest objections on the

part of the laity is the horror at having the body touched with the knife after death. To some it would be sacrilege to even mention autopsy. Others, again, fear demons will remain in the house, and all sorts of ghosts might come and pester them, while others without any reason whatever, will not permit the most superficial investigation after death, and yet they will permit the embalmer to ply his art without a word of murmur. All these objections I consider groundless and we as physicians should endeavor to disabuse the minds of the people; we should show them the fallacy of such a position, and that it is based upon superstition, and an heirloom of the dark ages, and thus secure their co-operation whenever and wherever opportunity affords.

Another important matter is the manner of conducting a post-mortem. The physician in charge should see to it that everything is in readiness, and that there be sufficient time allowed for the operation. If done in a bungling and unscientific manner, there is not the opportunity to study the relation of the parts diseased to the healthy structure and the very object sought is lost, the disease is not properly located, and many of the phenomena shown during life are not explained by the autopsy.

One of the most damaging obstructions to obtaining cases for autopsy is the attempt on the part of the physician to explain in detail the result of an autopsy before the body is examined. The laity know nothing about either the normal or abnormal condition of the tissues, and since many of the changes are not perceptible to the naked eye they are but misleading appearances to them. The autopsy should be in a manner private, and unless the case is a very plain one nothing should be said about it to the outside world, and in case of disagreement or disability to find the cause or seat of disease, the place for discussion is in the society meetings and not elsewhere, for nothing so affects the confidence of the people in medical men as their open hostility to each other. The

preservation of specimens is a matter of no little importance, and since this society has been organized under such favorable auspices I would offer as a suggestion that steps be taken towards procuring a repository for such specimens as are of importance and interest to the society, and this will help to bring about confidence on the part of the community in our efforts to serve them. There is no doubt but much good can be done by united effort. Surrounded as we are on every side by advertising charlatans, we must be up and doing, or be ostracized by the people at the hands of unscrupulous advertisers. Our medical societies and pathological institutes are our bulwarks. Let us pull together and discuss all questions pertaining to medicine in a way that will convince the people that we are honest practitioners seeking not our own aggrandizement, but their good as well, and that we know no secret nostrums, but are always ready and willing to employ every known legitimate means for the benefit of mankind.

Society Reports.

CLINICAL SOCIETY OF MARYLAND.

STATED MEETING HELD JUNE 6TH, 1890.

The 236th meeting of the Clinical Society of Maryland was called to order by the Vice-President, Dr. Wm. H. Norris, in the chair.

Dr. B. B. Browne presented the following

SPECIMENS.

1st.—Right pyosalpinx. Laparotomy performed and patient recovered.

2nd.—Papillomatous sarcoma. Laparotomy was done and patient made good recovery.

3rd.—Right tube and ovary. Recovery.

4th.—Left haemato-salpinx. Recovery.

5th.—Right tube and ovary. Laparotomy performed, followed by death on fourth day from apparent septicæmia.

In all of these cases there was a history of previous gonorrhœa. Gonorrhœal poison does not affect mucous membrane covered with pavement epithelium, but only that in which the columnar variety is found.

6th.—Specimen of double salpingitis and cystic ovaries. Recovery.

7th.—Case of double salpingitis and cystic ovaries. Drainage-tube removed on the fourth or fifth day, and wound closed, followed shortly by rise in temperature. Examination showed pus. Patient died.

8th.—Case of double salpingitis. Also movable kidney. The peritoneum was curetted in the hope of setting up an adhesive inflammation which would hold the kidney in place.

Many women have latent gonorrhœa which, extending to the tube and ovary, set up the troubles of pyosalpinx etc.

Dr. Tiffany thought the discussion about latent gonorrhœa useless, unless the gonococcus was shown to be present. Gonorrhœa affects the conjunctiva which is covered with pavement epithelium.

Dr. J. W. Chambers said that when gonorrhœa had become latent, the surgeon no longer knows anything about it. He regarded specimen No. 6, as far as he could judge, normal.

Dr. B. B. Browne thought the demonstration of the gonococcus often very difficult. In seven of the eight cases reported, there had been symptoms of gonorrhœa. In case No. 6, the woman had suffered with dysmenorrhœa, and the tubes were enlarged.

Dr. Tiffany asked Dr. Browne if he had ever found the gonococcus in any case of latent gonorrhœa.

Dr. Browne said that he had not.

Dr. Tiffany continuing, said that in his opinion no amount of curetting the

peritoneum would ever cause a floating kidney to become fixed.

Dr. L. McLane Tiffany read a paper on

THE REMOVAL OF A SOLID TUMOR FROM THE LIVER BY LAPAROTOMY.

The patient was a farmer, æt. 25 years, with good family history and good health until present illness. He first noticed pains in the left side about ten years ago. In July 1886, he had a congestive chill, following which he had pain in the right side, which continued until one year ago, when it subsided. Six months ago he noticed a swelling to the left side of middle line and also slightly in the epigastric region. This was tender on pressure. The urine which was passed in large quantities gave negative results on examination. A five inch incision was made in the line of the fibres of the left rectus muscle, the tumor was found on the convex surface of the liver, was removed with curved scissors and the wound cauterized. The size of the cavity left was about that of a walnut. Patient now recovering, eighteen days from time of operation the bowels are constipated and the amount of urine diminished. The tumor contained a small amount of biliary calculus.

Dr. I. E. Atkinson read a paper on a case illustrating

THE OCCASIONAL VALUE OF VENESECTION IN ORGANIC HEART DISEASE.

Dr. George J. Preston read a paper reporting a case of

LANDRY'S PARALYSIS.

No further business the society adjourned.

W. J. JONES, M., D. Sec'y,
1238 Greenmount Ave.

MARYLAND MEDICAL JOURNAL

Weekly Journal of Medicine and Surgery,

WILLIAM B. CANFIELD, A.M., M.D., Editor

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BALTIMORE, OCTOBER 18, 1890.

Editorial.

THE CLINICAL TESTING OF DRUGS.

Although the properties of the drugs in common use by physicians have been carefully studied and noted by masters in therapeutics, there is work in this department still for every observant physician.

Unless the young doctor has one of those phenomenal memories which retains and stores up ready for use the numerous complicated prescriptions with which the text-book of antiquity and the college professor's lectures of to-day,

written generations ago, are filled to repletion, he had better shun, as a rule, the ready-made prescription, and carefully build up for himself a knowledge of the individual properties of each drug of his armamentarium, testing each by itself and joining one to another in his prescriptions only as he can give some definite reason, from his own experience, for the combination. He will thus become, not a mere agent and tool of other men, but a master workman stamping the impress of his own individuality upon his own work. Moreover, he will thus escape the confusion of the physician who, having used a mixture of many drugs with ill results, is unable to determine to which one of them the trouble is due.

These drug-studies should be conducted at first by the light of the experience of eminent teachers, but after a while, the enthusiastic clinician will branch off into independent lines of investigation, using his own observations as a guide, and, meditating upon the conditions present and the results obtained, will apply in each new case the remedies which his past experience teaches him to be most suitable to the conditions present, without much regard to the name by which the disease has been labelled. Not that he underrates the value of exact nomenclature, but because special remedies, good for all cases of the same name, are almost unknown.

In pursuing this course of clinical self-education, the physician will not be seduced into following the multitude in the mad rush after the latest drug-fad. He will steer his course not by the comets which illumine the heavens for a few weeks only to pass again into oblivion, but by the fixed stars which, though not

so brilliant perhaps, shine steadily from generation to generation. He will sit with reverence at the feet of careful investigators whose labors for humanity are now ended, realizing that many a useful drug is forgotten in the race for novelty. He will listen with patience to the observations which thoughtful patients have made in regard to their own cases.

This habit of mind is the very essence of success in medical practice (considered apart from money-making). It lends exceeding interest to the daily routine, it stimulates to study in spare hours, it furnishes the mind with a rare insight into disease and its treatment which even the gift of genius, unaided, cannot bestow.

There is one vicious habit against which it is necessary to warn the young investigator. It is the custom of combining the drug, whose properties it is desired to test, with similar drugs of acknowledged power. How often are accounts published in the journals of trials of uncertain drugs, which upon careful perusal reveal the fact that the tested drug has been given in conjunction with a powerful agent of the same class! Thus, a writer will go into transports over the sedative power of some new vegetable extract, which he tested *in combination with extract of opium*, or over the anti-malarial influence of some new agent, which he gave several times daily *in alternation with quinine*.

It is strange that the unreliability of such records and the reflection which they cast upon the intelligence, if not the honesty, of the author are not apparent to every one.

THE TREATMENT OF ACUTE DYSENTERY WITH EPSOM SALTS.

Dysentery occurs in all regions, but it is particularly severe in the tropics, hence an article on its treatment by Mr. A. W. D. Leahy, F. R. C. S., (*Lancet*, October 4th, 1890) of Hyderabad is of more than ordinary value.

Not being satisfied with ipecacuanha on account of its unpleasant nauseating effects, he began the use of Epsom salts, and in the face of much objection by his colleagues, has shown it to be a means of curing 92 out of 95 severe cases. This treatment is especially adapted to the acute stage, where there are fever, pain, tenesmus, and stools of mucus and blood. It lessens the hyperæmia and causes faecal evacuations, with the result of relieving the pain and the distressing straining.

His directions are as follows: "Take a sufficient quantity of sulphate of magnesia to saturate seven fluid ounces of water, and to this saturated solution add one ounce of diluted sulphuric acid.

The dose of this is a tablespoonful every hour or two in a wineglassful of water until it operates. Sulphate of morphia may be combined with it, or starch enemata with laudanum may be employed."

He has also used it in the following way: "A drachm of the saturated solution with ten drops of dilute sulphuric acid, are given every hour or two until the stools have become copious, faeculent, and free from blood and mucus, the temperature has fallen, and the pain and tenesmus have ceased. When the stools have become normal in colour and ap-

pearance, and the patient only passes two or three in the twenty four hours, an ordinary astringent mixture of acid with laudanum or tincture of Indian hemp, or a pill containing extract of opium, is usually all that is necessary to complete the cure. It is, of course, imperative to diet the cases with great care. It is especially with reference to this method of treating acute dysentery as an alternative to the treatment of the disease by large doses of ipecacuanha that I am of opinion the value of a saturated solution of Epsom salts will in the future be found paramount. Its advantages over ipecacuanha may be summed up as follows:

1. It has no depressant action on the system.
2. It neither produces nausea nor vomiting.
3. It quiets and soothes the patient.
4. Its physiological action on the mucous membrane of the intestines in relieving hyperæmia is sound, and by this means it probably prevents the formation of ulcers within the gut, places those which may have already formed into a condition most favourable for their healing, preventing the acute inflammatory process and engorgement of the mucous membrane leading to the death of more tissue, and thus bringing about a cure."

In the Health Report for last week, 25 cases of diphtheria were reported, and six deaths in the mortality list.

The Medical Society of the Woman's Medical College, held its regular meeting on Friday, October 10, 1890. Papers were read by Drs. I. K. Godfrey, E. F. Cordell, Pearce Kintzing, B. B. Browne, and R. Winslow.

Correspondence.

VIENNA LETTER.

BILLROTH'S CLINIC—A DESCRIPTION OF THE ROOM—TWO OPERATIONS.

Vienna, Sept. 20th, 1890.

Editor Maryland Medical Journal:

DEAR SIR:—In addressing the MARYLAND MEDICAL JOURNAL, I recognize in doing so that I am speaking to the mass of the medical profession in Baltimore, knowing that a letter to the MARYLAND MEDICAL JOURNAL will reach the majority of Baltimore physicians.

I could spend much time in describing the hospital, its inmates, how conducted, etc. I could speak of each and all the clinics, of otology under "Politzer," of ophthalmology under Prof. Fuchs, of surgery under Albert, Dittler, Ritt, Stellwag and others, of syphilology under Dr. Edward Lang, and many others, but it would not be of such universal interest as the one I have selected.

Is there one among my readers that has not heard the name of Billroth? Very few, I dare say. Yes, the sound of "Billroth" awakens in us an interest in surgery and is a synonym for surgery. It is of his clinic and the methods adopted there that I wish to call your attention in this letter.

In a previous letter to your JOURNAL, I had the privilege of describing the "Allgemeines Krankenhaus" or General Hospital of Vienna, and those that may have read it, will understand me when I say that the surgical clinic room of Professor Billroth is entered from the right hand side of the inner court, about half way from the entrance to the further end.

The room is perhaps 80 or 90 feet long, about 30 or 40 feet wide, and not quite as high, the ceiling flat and kalsomined, with a huge single gas lamp. Two large windows are behind us as we

stand facing the arena, and admit plenty of light, as they extend from the floor nearly to the ceiling. The room is oblong, and has none of the elliptical amphitheatre about it. The seats rise in tiers from the arena, but in a square way i. e., from each side. The arena is square, and has on each side 8 tiers of seats rising from it, and in front of it 3 tiers, that is toward the window, and behind it 4 tiers above the large double doors that give access to the arena. Everything here is white, the seats as white with paint as they can be, and none of that "artistic" carving one meets with in schools, and especially in clinic rooms of medical schools. On each side, steps lead up to the top row of seats, and an excellent view is obtained of the arena from all sides.

The arena is about 10 to 12 feet by 14 to 20 as near as I can judge, the floor is of cement and is inclined from the four sides to the centre at which place is a fancy perforated iron plate about 12 by 12 inches, and through which the water and blood escapes, no pans being used to catch the water, and as a consequence, the operator and assistants step around in water and upon a wet floor. We stand in front and on each side right and left. The seats rise in eight tiers, but before and in front of the seats are cases mounted upon chests of drawers; in the case on one side is kept the instruments which are made of aluminium mostly, except artery forceps and such pincers, all the handles of knives and large instruments are of aluminium. In the opposite case is kept such chemicals and drugs as are needed in a clinic room. In the drawers below the cases are many things, such as gauze, plaster, cotton, pans, etc.

Two large doors open into the arena from the opposite side; above the door is a clock and some engravings of eminent surgeons, and to the sides of these 2 large glass jars of corrosive sublimate solution, the one to the right being 1-3000, the one to the left being 1-5000. Both are colored with potassium perman-

ganate and have leading from them rubber tubes provided with a stop-cock, and lead to the middle of the arena overhead. On the right hand side of these large doors is a big table, upon which stand jars of carbolic acid solution and various things, to the left are two basins, over which are two spigots of water, one hot, and the other cold. Another table stands alongside of the instrument case and has two large pans filled with carbolic acid water and has the instruments therein.

Two long operating tables stand in the middle, covered with clean sheets, a small revolving table on rollers stands near one of the tables and has a small dish on it with carbolic acid water in it too, a small chair, or rather a stool, for it has no back, stands alongside of this. Now put three chairs around the edge of the arena and you have all of the inanimate objects of the arena.

The assistants in the arena stand waiting for the operation to begin, and are dressed in clean grey gowns with sleeves rolled up and hands cleaned. The patient is placed upon the table nearer the centre, and the other one is now pushed further away. The patient has been fully anaesthetized and the operation is about to proceed.

Operation No. 1. Our first patient is a boy, $\text{æt. } 18 \text{ or } 19$ years who has been suffering from empyema for the last three or four years he is extremely anaemic, as all such empyema patients are. Aspiration has been resorted to time and time again, but still the empyema progressed, and now excision of bits of rib has been decided upon and he has now been brought forward for that operation. It is a grave one, as the entire left lung has disappeared and it is fair to suppose that the right one is not in a thoroughly healthy condition. However, an operation is indicated. The professor begins the operation. The details of the operation are simple enough; it is the performance that is tedious and lengthy. The linear incision is made along the left side of the

thorax, from the axilla downwards, and a flap of skin, muscle and subcutaneous tissue is laid forward, the scapula is freed from the thoracic wall, and the arm and scapula held up by an assistant, and nearly nine entire ribs are excised, the ribs being passed around for our inspection at the close of the operation. I took particular pains to count the number of excised ribs, and there were nine, measuring each about five or six inches in length, and a large flap of skin, muscle, etc.

Having removed this much, of course the entire cavity of the left thorax was exposed; the heart could be seen beating in the middle, and the lung was a mere shriveled mass in the apex. The surface presented a suppurating appearance. The cavity was washed out with warm water, but this soon caused the patient such uneasiness that it had to be discontinued, as fatal results might ensue. During all this time the hypodermic injections of whiskey were used, but now at the end of the operation such prostration was manifested in the condition of the patient that an enema of ammonia solution (very weak, of course), was administered, and with immediate effect. The cavity was cleansed as best it could be, then a single layer of gauze was placed in the cavity, and upon this and in this packing of gauze was made from a continuous bandage similar to Sim's method of packing the vagina. Whether Sims obtained his idea from this place, or they from Sims, is a question. The method is common enough, and I suppose it is only the gynaecological method to give a name to everything and every method; so let us call this "Billroth's method of packing the thorax," even as we are taught how Marion Sims packed vaginæ, and have it demonstrated to us. When sufficient gauze has been placed in the cavity the entire thorax is bandaged and the patient removed and stimulated further with external warmth applied in various ways, and internal stimulants. The operation was a long one and the result awaits the future, but recovery is not to be hoped,

and if hoped will not follow, for the figure we see before us is so slight, so anaemic, and with one lung gone and the other hardly much better.

Operation No. 2. The patient that now is brought before us is a small baby, about 6 months old, with its long clothes dangling and its small chubby hands grasped and a face wreathed in smiles, and in its mouth a wadded handkerchief, upon which it sucks and bites vigorously, and throwing its hands and arms about joyously, "a bundle of reflexes." as one of my honored professors would always say in speaking of "reflexes," and it is a good simile, too. The child, the baby, is laid on the table. We see at a glance the trouble; it is only a nævus on its face about the size of an ordinary button, about $\frac{3}{4}$ inch in diameter; the nævus is on the right cheek. An assistant places the baby on the table and holds it, another assistant covers the face with gauze, cutting a small hole in it through which the nævus can be seen and manipulated. The Paquelin thermo-cautery is brought out and the metal tip is heated to a glowing white dull heat, and some fifteen or twenty plunges are made into the nævus to destroy the blood-vessels. The operation is successful, completed in a short time, and the case is removed.

I will write to you again very soon.

Yours very truly,

ARTHUR D. MANSFIELD, M. D.

THE GRACE HOSPITAL.

Detroit, Mich., Oct. 11, 1890.

Editor Maryland Medical Journal:

DEAR SIR.—The next regular examinations for position of Assistant to the House Surgeon will be held at the Grace Hospital on Thursday, November 13th, at 8.30 P. M. The term of service is eighteen months. First six months as junior assistant, second six months as

senior assistant, third six months as house surgeon.

Applicants must show evidence of graduation from a recognized homœopathic college; all applications to be addressed to the President of the Medical Board, the Grace Hospital, Detroit, Mich., and must be presented not later than November 10th, accompanied by certificate of good moral character.

Respectfully,

ROB'T. H. SILLMAN.

Reviews, Books and Pamphlets.

A Text-Book of Practical Therapeutics, with Especial Reference to the Application of Remedial Measures to Disease and their employment upon a Rational Basis. By H. A. HARE, B.Sc., M.D., Clinical Professor of Diseases of Children, and Demonstrator of Therapeutics in the University of Pennsylvania, etc. Octavo 632 pages. Cloth \$3.75, leather, \$4.75. Philadelphia: Lea Brothers & Co., 706 & 708 Sansom Street.

This is a very convenient work for student and practitioner. As its name indicates, it is very practical. After some general preliminary considerations, the author takes up the drugs in alphabetical order, the remedial measures other than drugs, food, and then in Part IV, gives the diseases and their treatment in order. A table of doses with a copious index ends the work. While some of the drugs are treated rather slightly, and others seem to be the author's favorites, they have all received enough attention for practical purposes. The book is brought up to the newest ideas, and contains the newest drugs up to date of its print. While it is hardly possible to show great originality in such a work itself, it is interesting to note the author's views, some of them at variance

with other writers. The author uses very good language in expressing himself clearly and concisely. The book is neatly printed in the usual style of the publishers.

Medical Diagnosis, with Special Reference to Practical Medicine. A Guide to the Knowledge and Discrimination of Diseases. By J. M. DA COSTA, M.D., LL. D., Professor of Practice of Medicine, and of Clinical Medicine, at the Jefferson Medical College, etc., Philadelphia. Illustrated with Engravings on Wood. Seventh Revised Edition. Philadelphia: J. B. Lippincott Co. 1890. Pp. 995. Price \$6.00.

The change from former editions is not great. The omissions being about equal to the additions, the size of the book is unaltered. The principal additions are in the bacteriology of phthisis, pneumonia, Asiatic cholera, and typhoid fever. The plate showing typhoid bacilli is rather misleading. The chapter on blood has been rewritten, and there are new plates in the article on parasites. The book is like the former editions, a valuable guide to the student, and a convenient help for the practitioner.

Drs. Bourneville and Bricon's Manual of Hypodermic Medication. By G. ARCHIE STOCKWELL, M. D., F. Z. S., Member of New Sydenham Society, London. Detroit: George S. Davis, 1890.

This work was noticed when it came out in Wood's Monograph in 1889. It is a very valuable work of reference, but hardly sufficiently so to merit its publication by different firms in the same country. Dr. Stockwell has added to the original by consulting the files of the *Index Medicus*. He also very naïvely expresses his obligations to Dr. A. S. Currie of England, "whose English publication has made my own work simple and easy." The similarity between Dr. Stockwell's and Dr. Currie's preface is

striking. The formulæ are not alike in both books, Dr. Stockwell's being according to the U. S. Pharmacopœia, while Dr. Currie's is made for the profession of Great Britain.

There has long been felt a want of just such a work to show the solubility and the hypodermic dose of drugs.

Hypodermic Medication in Diseases of the Eye. By CHARLES J. LUNDY, A. M., M. D., Detroit.

An attractive book to be issued this autumn is the autobiography of Jules Breton, which will have the title *The Life of an Artist*. It is a work of much personal charm and interest, written with an entire absence of reserve. It contains recollections of the Barbizon painters and others of world-wide reputation. The translation, by MRS. MARY J. SERRANO, translator of *The Journal of Marie Bash-kirtseff*, will be published in October, by D. Appleton & Co.

Herbert Spencer will contribute the opening article for the November number of the *Popular Science Monthly*. It is on the "Origin of Music," and extends the discussion in his essay on "The Origin and Function of Music," opposing Darwin's view that all music is developed from amatory sounds. A criticism by the late Mr. Gurney is also replied to in this article.

"School Life in Relation to Growth and Health" is the title of a paper by Prof. Axel Key, of Stockholm, to be published in the Novem'ber *Popular Science Monthly*. Prof. Key maintains that the studies of children, as now ordered, do not allow enough time for rest and growth, and urges a reform in this respect.

It is understood that Richard Malcolm Johnston has recently completed a novel which he regards as his strongest work. The title chosen is said to be *Widow*

Guthrie, and the novel is described as picturing various social phases in the Georgia of sixty years ago, with all the author's truthfulness and fine humor, and with an exceptional command of character and of dramatic effects.

The *Queen* pays all expenses.—*The Queen's* last "Free Trip to Europe" having excited such universal interest, the publishers of that popular magazine offer another and \$200 for expenses to the person sending them the largest list of English words constructed from letters contained in the three words "British North America." Additional prizes consisting of Silver Tea Sets, China Dinner Sets, Gold Watches, French Music Boxes, Portiere Curtains, Silk Dresses, Mantel Clocks, and many other useful and valuable articles will also be awarded in order of merit. A special prize of a Seal skin Jacket to the lady, and a handsome Shetland Pony to girl or boy (delivered free in Canada or United States) sending the largest lists. Everyone sending a list of not less than twenty words will receive a present. Send six U. S. 2c. stamps for complete rules, illustrated catalogue of prizes, and sample number of *The Queen*. Address *The Canadian Queen*, Toronto, Canada.

Miscellany.

A RAPID CURE OF TONSILLITIS.

Dr. A. S. Hudson of Stockton, Cal., (*Medical Record*, September 27, 1890) finds the following an invariable cure in acute tonsillitis:

R.—Norwood's tincture of veratrum viride	30 drops.
Sulphate of morphine	1½ grain.
Distilled water	6 drachms.

Of this, one teaspoonful to be taken every hour for two hours, and then every two or three hours, as needed.

THE RESTRICTION OF CONTAGIOUS
AND INFECTIOUS DISEASES. RULES
FOR THE GUIDANCE OF SANITARY
OFFICERS AND OTHERS.

DISINFECTION WILL BE PRACTISED IN ALL
CASES OF DIPHTHERIA, SCARLET FEVER,
TYPHOID FEVER, SMALL-POX, CHOLERA,
AND SUCH OTHER DISEASES AS MAY BE
HEREAFTER DESIGNATED.

Sanitary Inspectors will, at the time of making inspections, give such cautions and instructions to the householder as will tend to restrict the spread of the disease. Especial stress will be laid upon the importance of separating the patients from the healthy members of the family and of preventing unnecessary intercourse with other persons than those needed in the care of the sick.

In addition to making a careful sanitary inspection of the house and surroundings, the inspector will request the nurse or other person in charge of the patient to promptly put all soiled clothing, bed linen, handkerchiefs, napkins, towels, etc., *into boiling water*. This at once destroys all disease-germs. Table utensils, tumblers, etc., should also be scalded immediately after use and wiped with a *clean* towel. Spittoons or other receptacles for matters expectorated should be partly filled with a disinfectant solution of phenyle. This is especially important in diphtheria and scarlet fever.

In cases of typhoid fever, all discharges from the bowels should be received in a vessel containing about a quart of the phenyle solution, or if a bedpan is used, this should be immediately placed in a vessel of the disinfectant solution, or of boiling water.

The inspector will note upon a special blank the date of recovery or death of a patient from an infectious disease, so that proper disinfection may be carried out by the department.

When a house is reported ready for disinfection, the disinfecter will proceed

to the house with a supply of sulphur and a fumigator, and fumigate the room formerly occupied by the patient. All articles remaining in the room while occupied by the patient should be allowed to remain until after fumigation. Three pounds of sulphur should be used for every 1000 cubic feet of space in the room. (A room 10 feet long, 10 feet wide, and 10 feet high, contains 1000 cubic feet.) All windows and doors should be closed as tightly as possible, any cracks, crevices or other openings being stuffed with rags, pasted with paper, or in some other way made as nearly impervious as possible to the entrance of air, or the escape of the sulphur fumes. The room should be kept closed for 24 hours, when the windows may be opened and the room exposed to the air as freely as possible for 24 hours longer. The articles in the room, bedding, clothing, etc., should be spread out on chairs, etc., to allow the sulphur to act on all surfaces possibly infected. Carpets should not be taken up until after disinfection, unless they can be removed at the very beginning of the case.

After the fumigation, all washable articles should be washed in boiling water, and furniture, floors, etc., scrubbed with hot water and soap.

Articles of little value should be burnt. Walls, ceilings, etc., should, where practicable, be whitewashed.

Officers of the Health Department are not allowed to make any suggestions or comments upon the medical treatment of cases, or indulge in any criticisms of the attending physicians.

Disinfecting solution of phenyle may be made by thoroughly mixing one teacup full of Little's Soluble Phenyle with one gallon of water.

GEORGE H. ROHÉ,
Commissioner of Health.

ECZEMA FROM THE USE OF CREOLIN.

Quite a number of cases, according to the *Therapeutic Gazette*, have recently

been reported in which more or less unfavorable results have followed the employment of creolin, in the majority of cases the effects being attributable to the phenic acid and its derivatives in this proprietary remedy. In the *Gazette Médicale de Paris*, No. 29, 1890, a report is published of a case observed by M. Borehmeyer of a child, two and one-half years of age, whose finger was crushed between cog-wheels, by which a severely-contused wound was produced, which was treated by applications of a one and a half per cent. solution of creolin. On the fourth day the finger was covered with vesicles, both small and large, which ruptured spontaneously, giving issue to a yellowish liquid. The eruption soon disappeared from the injured hand, and, on the removal of the application, a cure was rapidly produced, though the eruption again returned on renewed application of creolin. So also Dr. Wackez publishes an account of seventeen different surgical cases treated by creolin. In ten of these, union by first intention occurred; in seven the creolin produced eczema, erythema, and vesicular eruptions, and desquamation of the skin in large patches; at the same time the patients had more or less severe constitutional disturbance, and an examination of urine showed that these poisonous effects were attributable to the presence of phenol. It would seem, however, that children are especially susceptible to the deleterious effects of phenol and its derivatives, and hence are more readily influenced by creolin.—*Boston Med. and Surg. Jour.*

ÆTHYL BROMIDUM.

Three cases of poisoning from æthyl bromidum have recently been reported from Berlin, where it seems to be much used as an anæsthetic for dental as well as for small surgical operations, and Dr. Mittenzweigs warns people against its employment. Some years back æthyl bromidum was used in this country extensively, as it has the advantage of acting quickly and rarely producing sick-

ness, but the number of fatalities attending its use has led to its loss of popularity. As far as we know it is a drug but little, if at all, employed by English dental surgeons.—*Brit. Med. Jour.*

FAILURE OF THE SALOL TREATMENT OF CHOLERA.

Surgeon J. H. Tull Walsh, attracted by the favorable report of Dr. Nicholson, as to the good results of the treatment of cholera by salol, has tried it in a succession of 14 cases treated in the Puri Cholera Hospital; there were, however, 11 deaths out of 14 cases—giving a death-rate of 78.5 per cent. A miscellaneous treatment with stimulants and astringents gave better results. He considers that Hueppe and Lowenthal, who first recommended this drug, have only succeeded in adding one more to the number of medicines that will not cure cholera.—*Brit. Med. Journal.*

CHLOROFORM LINIMENT.

R.—	Chloroform	4 ounces.
	Camphor	1 ounce.
	Fluid vaseline, q. s.,	8 ounces.

Dissolve the camphor in the chloroform and then add the fluid vaseline. Of course, the amount of vaseline may be varied according to the strength of the liniment desired. It is said that this makes a much more useful application than chloroform liniment made with olive oil.—*Med. News.*

POINTS TO BE OBSERVED BY ELDERLY MALES.

Dr. R. Harrison (*Medical Press and Circular*) says:

1. To avoid being placed under circumstances when the bladder cannot be emptied at will. Nothing is so bad for a large prostate, though it may be working satisfactorily, as an enforced retention. It is often the first cause of a permanent atony.
2. To avoid checking perspiration

by exposure to cold, and thus throwing additional work on the kidneys. In climates like our own, elderly persons should, both in summer and winter, wear flannel next the skin.

3. To be sparing of those wines and spirits (if used at all) exercising a marked diuretic effect either by their quantity or quality; select those which promote digestion without palpably affecting the urinary organs. A glass of hot gin and water, or a potent dose of sweet spirit of nitre, will not do anything to remove the residual urine behind an enlarged prostate.

4. To be tolerably constant in the quantity of fluids daily consumed. As we grow older our urinary organs become less capable of adapting themselves to extreme variations in excretion. Therefore, it is desirable to keep to that average daily consumption of fluids which experience shows to be sufficient and necessary. How often has some festive occasion, where the average quantity of fluid daily consumed has been largely exceeded, led to the over-distension of a bladder long hovering between competency and incompetency. The retention thus occasioned by suspending the power of the bladder, has frequently been the first direct step towards establishing a permanent, if not a fatal, condition of atony or paralysis of this organ.

5. It is important that from time to time the reaction of the urine should be noted. When it becomes alkaline or offensive, the use of the catheter may be necessary. When a catheter is required it is most important that its selection should not be left entirely to the instrument maker. There are other points to be considered beyond the fact that it is to serve as an artificial outlet for the urine from the bladder. An unsuitable catheter in a prostatic case may do much permanent harm.

6. Some regularity as to the time of performing micturition should be inculcated. We recognize the importance of this in securing a regular and healthy action of

the bowels, and though the conditions are not precisely analogous, yet a corresponding advantage will be derived from carrying out the same principle in regard to micturition.—*Cincinnati Lancet-Clinic.*

THE DEADLY COLD BED.

If trustworthy statistics could be had of the number of persons who die every year, or become permanently diseased from sleeping in damp or cold beds, they would probably be astonishing and appalling. It is a peril that constantly besets travelling men, and if they are wise, they will invariably insist on having their beds aired and dried, even at the risk of causing much trouble to their landlords. But the peril resides in the home, and the cold spare room has slain its thousands of hapless guests, and will go on with its slaughter till people learn wisdom. Not only the guest, but the family often suffer the penalty of sleeping in cold rooms, and chilling their bodies, at a time when they need all their bodily heat, by getting between cold sheets. Even in warm, summer weather a cold, damp bed will get in its deadly work. It is a needless peril, and the neglect to provide dry rooms and beds has in it the elements of murder and suicide.—*Drug-gists' Circular.*

MR. HUTCHINSON'S TREATMENT OF RINGWORM.

Mr. Jonathan Hutchinson gives, in his *Archives of Surgery*, the prescription upon which he has "settled down in tolerable content" for the treatment of ringworm, after having tried a great variety of remedies without equal satisfaction. He relies chiefly on chrysophanic acid. He orders as a wash for the scalp one drachm of Wright's liquor carbonis detergens to the pint of hot water. Twice a week the scalp should be well washed with this, and all scales and crusts should be removed. The hair is cut close or shaved. The chrysophanic-acid ointment contains a drachm of chryso-

phanic acid, twenty grains of ammoniated mercury, a drachm of lanoline, six drachms of benzoated lard, and ten minims of liquor carbonis detergens. This ointment is to be rubbed in more or less freely, according to its effects, night and morning, or latterly every night only. The cure will be slow probably, and the secret of success consists in the patient continuance of the same remedy. To those who persevere he promises recovery; it is only the impatient who are disappointed. He has no faith in the rapid cure of ringworm.

MASSAGE IN HEADACHE.

Dr. Norström, finding that a good many cases of headache occur where, though the symptoms are more or less like migraine, the remedies suited to that affection are of but little use, examined the heads of such patients carefully, and came to the conclusion that the pain must depend upon inflammatory thickenings existing at the insertion of various muscles, especially the sterno-mastoid, the temporal, the scaleni, the trapezius, and the occipito-frontalis. These indurations do not usually produce any local pain, and therefore are generally unnoticed both by physician and patient. They are commonly the result of "taking cold," and the headaches they caused can be traced to change in the weather. Dr. Norström obtains excellent results by regular massage of these indurated spots, the sittings lasting for about a quarter of an hour. Similar treatment is also efficacious where the headache is due, as it sometimes is, to enlarged lymphatic glands. Of course, little result can be expected from massage in headaches of anæmic or of hysterical origin, or where there is organic cerebral disease.

—*Lancet.*

QUININE IN SEA-SICKNESS.

M. Charles Richet records that he has used this substance with marked benefit in sea-sickness. The subject was a person extremely susceptible to sea-sick-

ness. The result of the treatment recommended to him by M. Richet was excellent, for everyone on board was said to be suffering save himself. M. Richet suggests that the beneficial action of the quinine in these cases may be somewhat similar to its analogous action in Ménière's disease, where many times the symptoms resemble closely those of seasickness. He advises that a gramme be taken about two hours before embarking. At the same time he is careful to add that other well-recognized and often successful precautions should not be neglected, such as the recumbent position, with plenty of air, &c. Here, then, according to M. Richet, we have another infallible remedy added to the thousand and one well-established ones. Surely after this, sea sickness will be a thing of history!

OINTMENT FOR CHAPPED HANDS

According to the *Journal of Cutaneous and Genito-Urinary Diseases*, the following is an excellent application for chapped hands: Dissolve one part of boric acid in twenty-four parts of glycerine; add to this solution five parts of anhydrous lanoline and seventy parts of vaseline. The mixture may be colored and perfumed.—*Weekly Medical Review.*

SCARLATINA WITHOUT PYREXIA.

Dr. Wertheimer mentions in the *Münchener Medicinische Wochenschrift* a case of scarlatina occurring in a child seven years of age, in whom, though the eruption was well marked, and the tonsils and tongue presented their characteristic appearance, there was absolutely no pyrexia either morning or evening, the highest point reached being 99.6° F. The pulse, however, was rapid, being from 116 to 120 during the first three days. There was no albuminuria; desquamation began on the ninth day. Dr. Wertheimer also mentions a second case occurring in a child of about the same age, where, though all the distinctive signs of scarlatina were present, the only

time there was any abnormal temperature was the evening of the second day; then it was 100.6°. Here, too, there was marked rapidity of pulse, and he suggests that this is probably an important sign in diagnosing the rare cases of apyrexial scarlatina. His opinion is confirmed by Dr. Beetz, who immediately after the appearance of the article reported two other apyrexial cases where the pulse was also very rapid.—*Lancet.*

a little filled out with details and published in pamphlet form.

It is calculated, on the basis of statistics, that the average duration of the lives of medical men in Prussia, from the end of the thirtieth year onwards, is somewhat below that of the total male population of the country, though the latter includes a large number of decrepit and diseased persons, such as the nature of the medical profession excludes.

Medical Items.

The Southern Surgical and Gynecological Association will meet at Atlanta, Ga., November 11th, 12th and 13th, 1890.

Fears (or hopes), are entertained by some physicians that another epidemic of influenza is making its appearance for the season.

Under the new tariff law foreign medical books printed in any other language than English are admitted without the payment of duty.

The semi-annual meeting of the Medical and Chirurgical Faculty of Maryland will be held on the Eastern Shore in the second week of November.

In the beginning of this year the population of Berlin was over a million and a half, the number of its physicians and surgeons 1,398, of its dentists 107, of its privileged pharmacies 120, and of its hospitals 34, with 4,635 beds.

Gaillard's Medical Monthly for October says: Dr. H. P. C. Wilson, of Baltimore, has contributed an interesting series of letters to the MARYLAND MEDICAL JOURNAL during his brief sojourn in Europe. They could easily be made generally entertaining to the profession if they were

A few months ago, Dr. Arnold, of Zug, pointed out that compressed tablets of antipyrin, antifebrin and other medicaments, sometimes passed the patient's digestive canal unchanged. Referring to his note, the *Schweizerische Wochenschrift für Pharmacie* points out that the drawback can be easily prevented by the manufacturer; it is sufficient to interpose a layer of powdered sugar or tragacanth between the layers of the tablets. The purchaser should always ascertain by experiment whether or not the tablets are soluble in water. If they are not so, they are, of course, useless.

Dr. Brunon recently reported to the *Société de Médecine* of Rouen the case of a primipara whose labor was so nearly painless that she herself mistook it for difficult defecation and would have been delivered in the water-closet if she had not been removed from it. According to the abstract published in *La Normandie médicale*, she felt only lumbar pains and a sense of weight in the rectum, and was not aware of the flow of liquor amnii. The author infers from this case that the discovery of a new-born infant in a water-closet pan does not necessarily raise the presumption of premeditated infanticide.

At the dinner of the Ophthalmological Section of the International Medical Congress at Berlin, Professor Hermann Cohn, of Breslau, showed a collection of autographs of the oculists who had taken part in the annual meetings at Heidelberg for

twenty years, which was made specially interesting by the fact that opposite each name the signatory's visual power with the right and left eye respectively was indicated. Among other celebrities who figured in this last were Arlt. Horner, the elder Critchett, Schweigger, and Knapp. Among 44 oculists tested, visual acuity was normal in 32, over the normal in 10, and under it in 2. Twenty-eight, or 61 per cent., were shortsighted; the concave glasses required varied between Nos. 5 and 24, the average being 20, so that the myopia of the distinguished ophthalmologists in question was, as a rule, moderate in degree.

By direction of the Secretary of War, the following changes in the stations and duties of Officers of the Medical Department are ordered: Major George M. Sternberg, Surgeon, is relieved from duty as Attending Surgeon, and Examiner of recruits at Baltimore, Md., and as a member of the Army Medical Board appointed to meet in New York City, N. Y., and will repair to San Francisco, Cal., and take charge of the Medical Purveying Depot at that place, as Acting Assistant Medical Purveyor, relieving Col. D. J. D. Irwin. Surgeon-Colonel Irwin, on being thus relieved, will report in person to the Commanding General, Department of the Columbia, for assignment to duty as Medical Director of that Department, and as Post-Surgeon, Vancouver Barracks, Wash., relieving Major William E. Waters, Surgeon, now Post-Surgeon, and temporarily in charge of the Medical Director's Office. Major Waters, on being thus relieved, will report in person to the Commanding Officer, Fort Custer, Mont., for duty at that station.

There are only two public employments open to foreigners in France—scavengers and ragpickers. Applicants are eligible for the duties on supplying a name and giving a nationality. Antecedents are not pried into, but the applicants are ex-

pected to have at least a clean police bill of health. A great many of the ragpickers have seen better days, but it is sheer romance to assert that these last social tritiae are largely recruited from swindling bankers, unfrocked clergymen, wrecked savants or ruined professionals. As a rule, till recently, the ragpickers have had the reputation for sterling honesty, as evidenced by the immediate restoration of invaluable finds in the refuse heaps to their owners. They form a caste in themselves, live where few other persons could exist, and on food of questionable origin. Drink is their main vice, and any firewater is acceptable, provided it titillates the palate, warms—that is, burns—the inside, and produces seeing double and enthusiastic oblivion. Disease is as rare among chiffoniers as among grave-diggers and sewer men. It is for the Berlin Medical Congress to explain this hygienic paradox.

The establishment of a uniform nomenclature in anatomy, which was taken in hand by German anatomists about a year ago has now become an international affair; and the committee appointed for the purpose, which has hitherto consisted exclusively of Germans, now numbers three foreign members—namely, Leboucq of Geneva, Cunningham of Edinburgh, and Romiti of Pisa. The expenses of the task are to be borne by the learned corporations of Germany, because the Anatomical Society, which began it, does not possess the necessary funds. The Prussian, Bavarian, and Saxon Academies of Science have contributed 1,500 marks (\$375), each, the Academy of Vienna 1000 gulden (\$425), and the Anatomical Society 1,000 marks (\$250). The completion of the work will be entrusted to a commission, presided over by Professor von Kölliker of Würzburg. The preliminary work is to be done by an anatomist of special qualifications, including the necessary philological attainments.

MARYLAND MEDICAL JOURNAL.

VOL. XXIII. No. 26. BALTIMORE, OCTOBER 25, 1890.

NO. 500

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CERTAIN CAUSES OF MAJOR PELVIC TROUBLES, TRACEABLE TO MINOR GYNÆCOLOGY.*

BY JOSEPH PRICE, M. D.,
OF PHILADELPHIA.

With the present popular cry of "conservatism," in reference to operation in cases where it is held that all treatment should be tried previous to real surgical interference, it is worth while asking whether this preliminary treatment should not itself be abandoned in the hands of those who plead most pathetically for it. Their cry is not a scientific plea, but in most instances a *personal bid* for indulgence while they try to ac-

complish something, without acknowledging on the one hand that there is little or nothing to encourage them in their work, so far as results are concerned; and on the other, that there are abundant proofs from the cases that have come out from under their hands, with one treatment or another, that manifold really major surgical affections arise merely from treatment recognized as orthodox from the standpoint of minor gynæcology. So far as my own experience is concerned, I do not hesitate to put minor gynæcology in a causal relation with a vast amount of the necessary major pelvic surgery coming under my attention.

First among these causes may be mentioned the Emmet cervical operation. Like many other surgical operations, this, when first explained by its distinguished originator, was done in season and out, by everyone, without the least consideration of its contra-indications. Very many minor tears of the cervix, in

*Read before the Philadelphia County Medical Society, September 24th, 1890.

which a cosmetic effect only is obtained by operation, are made distinctly worse by operative interference. In many cases the pain becomes insufferable, from the lighting up of a dormant or unrecognized pelvic trouble, and operation is required to undo the mischief of an unnecessary cervical closure. This fact has been recognized by Emmet himself, and he has counselled the careful selection of cases in order to escape these disastrous results. It should be set down that where there is preexisting pelvic disease, even though slight, no cervical operation ought to be tried unless absolutely required by the condition of the patient. Another operation which has met with much approval in many directions, and which some measure of success seems to follow in some cases, is the forcible dilatation of the cervix. It is clear that where there is antecedent inflammation of the pelvic viscera, that is of the genito-urinary system, such an operation as surgical dilatation of the cervix cannot be free from danger. In order to relieve dysmenorrhœa by this procedure, it must evidently be due to stenosis of the os or cervix. The question here arises, can it be told, in dysmenorrhœa, wherein its causes lie? Sometimes, but not infallibly. The fact is, that in many women where a stenosis would be diagnosticated, there is no difficulty whatever attending the menstrual flux. This being the case, it is evident that a diagnosis cannot be made by simple observation without a careful study of all of the symptoms. Again, in many women the causes for this condition are complex. It will not do to lose sight of this, and conclude that because a flexion exists dilatation will remedy menstrual pain. It is to be remembered that if there is co-existing pelvic inflammation dilatation will increase it, and, under certain conditions, cause it if absent. Rapid dilatation of the cervix is a distinct traumatism, and along with it run all the dangers incident to septic absorption that attend any other violent procedure, and where traumatism incident to nat-

ural causes is confessed to be the cause of so much subsequent mischief, it ought not to be *expected that operative injury can be harmless*. This conclusion, reached inferentially, has been abundantly confirmed practically on the operative table by much of my later pelvic work. In a number of cases with a history of preceding dilatation, the after operation has exhibited an inflammatory condition of affairs as complicated as any other in my experience. Some of the dilatations were done with preexisting disease, which was made worse by this interference, while others were done simply to relieve the dysmenorrhœa, and resulted in the establishment of a complicated surgical disease in which operation was *necessary purely to save life*. All in all, I believe that, judged simply by its remoter effects, the operation of rapid dilatation is a dangerous one, and *results oftener in subsequent harm than in lasting good*. The surgical injury to the cervix is, in many of these cases, more pronounced than the tears of the cervix which it is the intention to remedy by Emmet's operation. In this case there is operation at each horn of the dilemma, and the results are often equally bad at both. Simple closure of the cervix in cases of pelvic disorder, almost certainly exacerbates the symptoms. The necessary inflammatory action set up in the suture tract, is transferred along the lymphatic or venous channels to the seat of the earlier inflammation, this is lighted up anew, and goes on in its development until a pelvic peritonitis is kindled or rekindled, which at last entails a major operation. The minor gynæcologist, as such, who has no regard for, or appreciation of the relation of the commonly advocated general closure of perineal and cervical tears to major surgical complications, cannot but be a great factor in the causation of the same. In Pepper's *System of Medicine*, vol. iv., there is on record a case in which the operator hoped to cure a pelvic inflammation by the derivative effect of a perineal or cervical operation. Needless to say, pelvic

operation was afterwards done. Such a cure is no less ridiculous than the so-called "faith" cure, and is certainly more actively harmful.

That the inconsiderate use of the uterine sound has been responsible for much inflammatory pelvic trouble, is scarcely to be disputed. This is not because the sound is of itself a dangerous instrument, but because it is put into the hands of every tyro, as an instrument of diagnosis. If used at all, it should be in the hands of those with whom its application, by reason of their skill, will be exceptional, not usual, and the rule should be, that in the hands of the non-expert it should be forbidden. The more expert and experienced the specialist, the more rarely will the instrument be required. My own rule is, that in cases in which it might at first seem indicated, a little patience and diligence will obviate the necessity of employing it. The indiscriminate use of the sound and electrode, is the most serious MECHANICAL objection to the employment of electricity. Every sitting for the electrical treatment is prefaced by the use of the sound, and followed necessarily by the introduction of an electrode of some form. This is by a class of men who, in the main have had no previous gynaecological training or education whatever. In such hands such methods can only be harmful, and we are now reaping the fruits of their work in a class of pelvic operations not surpassed in the complications presented. Along with the sound may be placed the curette in the same category. Dilatation, with curetting of the uterus, have placed to their credit a long series of major operations.

Another class of cases coming under this head are those in which there has been a long time during which intra-uterine applications have been made. All the caustics in the catalogue have at one time or another been in favor, as cure-alls, in intra-uterine therapeutics. Nitric acid, chromic acid, nitrate of silver, and the rest. For a woman to have

undergone a routine treatment with this list, and to have escaped pelvic inflammatory trouble, is little short of a miracle. A careful inquiry into many of the cases coming under my care directly and indirectly, reveals the history that all sorts of minor procedures were tried, only to fail and apparently hasten the necessity for operation. I shall refer to and illustrate these points by the citation of cases in the discussion.

ERYSIPelas.*

BY D. OLIN LEECH, M. D.,
OF WASHINGTON, D. C.

Mr. President and Gentlemen:—In selecting my subject for the evening, I do so, not with the intention of bringing out anything new or saying anything that we do not know, but to hastily review the ground already covered by numerous authors, and report several cases that have come under my immediate observation, thus hoping to elicit a discussion which may prove of benefit to us all. Erysipelas in its various forms to my mind, is one of the most important diseases to treat, with which the general practitioner comes in contact.

Erysipelas we are told, is a self limited febrile affection, classed among the eruptive fevers, affecting the skin, through to subcutaneous connective tissue, is also contagious as well as infectious, the direct cause being due to the entrance through an abrasion or mucous surface of a specific poison, the now mighty little animal, the microbe, the chain-coccus of Fehleisen, although the theory has been tried to be disproved by some, the weight of opinion is now strongly in favor of the germ theory.

There are two forms, the idiopathic and traumatic, the phlegmonous cellulocutaneous. Where it goes beyond the deep

*Read before the Clinico-Pathological Society of Washington D. C., April, 15th, 1890.

fascia, attacking the muscles, and deeper organs it may be either idiopathic or traumatic, more common among men than women, between 20 and 50, though it attacks all ages, occurs at all seasons, though it is more prevalent during the winter and spring.

Pathology.—It shows the whole thickness of the skin as well as the subcutaneous connect tissue to be involved, which is also edematous and infiltrated with serous fluid composed mainly of white blood corpuscles and it is teeming with micrococci. Abscesses sometimes formed by the accumulated coalescence of cells, inflammation subsiding, a granular disintegration of the cells takes place, a portion entering the lymph vessels, the rest being absorbed, leaving the skin in its normal condition.

Symptoms. — Erysipelas is usually ushered in by an initial rigor, headache, fever, general malaise, nausea, vomiting, and in many cases anorexia. The typical signs of inflammation, heat, redness and swelling, the part affected becoming tense with a glazed appearance, the area of inflammation being sharply defined. Pressure causes the red color to disappear, returning again as well as edema. The lymphatics in the region of the inflammation may be enlarged and tender. Phlebitis occasionally occurs. Temperature varies from 100° to 104° or 105° , pulse proportionately constitutional, symptoms vary with the severity of the attack. In simple or cutaneous variety, symptoms, course and duration are usually mild. In the cellul-o-cutaneous or phlegmonous, severe and even fatal blood-poisoning is not uncommon. In erysipelas of the extremities, gangrene is occasionally met with, the part beyond the extremity being sacrificed from the stoppage of the circulation. The duration of erysipelas may be from a week to several weeks, according to the severity of the case. During the first two days, erysipelas may be mistaken for dermatitis, phlebitis, lymphangitis or cellul-o-dermatitis. I have seen two cases of simple

erythema that were mistaken in the beginning for erysipelas.

Prognosis.—Erysipelas as a rule, unless of the phlegmonous variety with some complications, is not dangerous.

I have seen a number of cases occurring about the head and face, get well, without any serious trouble, although some of the authors claim that the prognosis, when in these locations is less favorable than anywhere else. In the phlegmonous, accompanied with suppuration and infiltration of pain, the prognosis is not so favorable, septicæmia setting up, proving rapidly fatal.

Treatment.—Isolation as far as practicable, as little furniture in the room as possible, and plenty of ventilation, temperature of about 72° , not too much covering on the bed. No one to be admitted into the room except the nurse and physician. The physician should guard against carrying the germ to any surgical or obstetrical case by proper disinfection, and here comes up the question, should he attend any obstetrical or surgical case while attending a case of erysipelas?

The local measures employed are many—the application of ointments, cold and hot applications, painting with iodine, Higgenbottom's plan of using a solution of nitrate of silver and antiseptic gauze treatment. The injection of carbolic acid a short distance from the line of redness is of doubtful efficacy. I have seen one case in which this was done with no good result as far as I could judge, the patient dying. If the tension is great and pains severe, puncture or short incisions, letting out the serum, even should there be no pus. Applications of a solution of lead and opium, on absorbent lint or cheese cloth to the inflamed part. Then comes the internal treatment; first, to support the patient, keeping in mind the possibility of septic absorption. Keep the intestines working gently with a saline laxative. Many use 1 gr. of aconite if pulse is rapid and fever high. Antipyrine is highly recommended by some; I would rather

not on account of its depressing effects on the heart. Tinct. ferr. chlor. 10 to 30 drops every two to four hours; quinia in full doses; quinine in combination with belladonna; in delirium, bromides with chloral.

CASE I.—Dr. D., returning home one cold night, pulled his hat down close on his forehead and walked rapidly; he soon felt a smarting in the center of forehead; took off his hat and rubbed his forehead vigorously with his hand. On reaching home, it pricked him. Looking in the glass, saw a small abrasion not much larger than a pin-point and an area of redness, about the size of a ten-cent piece. Put some vaseline on and thought no more about it until next morning, when he saw that the area of inflammation had enlarged to about the size of a half-dollar. Put on oxide of zinc ointment. Area of inflammation continued to increase; some headache, fever and a feeling of general malaise; no present chill. Sent for me that evening; I found an area of redness extending down into the loose tissue around the eye; the whole face and head became rapidly involved. Temperature on the third day was 103°. I put him on the following treatment: lead and opium wash constantly applied locally, 20 drops of ferri. chlor. every two hours, three grains of quinia sulph. every four hours; kept his bowels open gently every day with a saline. A nutritious liquid diet. Bromide to control restlessness. This case began to convalesce about the nineteenth day and was confined to the house for nearly four weeks.

CASE II.—Mrs. M.; inflammation began around the right ankle, of typical idiopathic variety, there being no abrasions that could be discovered. She was very heavy on her feet, having to stand and walk a great deal. Some tendency to varicose veins of the extremities; inflammation extended rapidly up the leg, the buttocks and lower part of the abdomen, as well as the left thigh, becoming involved, assuming the cellulo-cutaneous or phlegmonous type. The system was

very much depressed. Circumscribed pneumonia developed, which cleared up. Patient was in a semi-comatose state nearly all the time; took and retained her nourishment well. Everything was done in this case that could be done. Hot poultices locally, painting with iodine, nitrate of silver; injection of carbolic acid, etc. head and opium wash. Patient died on the twenty-fifth day.

THE TREATMENT OF HÆMORRHOIDS BY EXCISION.*

BY CHARLES B. PENROSE, M. D.,
OF PHILADELPHIA.

My object in presenting this paper is to urge the more general use of Whitehead's operation of excision in the treatment of certain cases of hæmorrhoids.

In 1887, Mr. Whitehead, of Manchester, reported † three hundred consecutive cases of hæmorrhoids which had been successfully treated by the method of excision and suture. His operation is performed in the following manner:

1. The patient is placed on a table in the lithotomy position, with the hips well elevated.
2. The anal sphincters are then thoroughly paralyzed by digital stretching.
3. The mucous membrane of the rectum is divided at its junction with the skin around the entire circumference of the bowel.
4. The mucous membrane, with the attached hæmorrhoids, is dissected from the submucous tissue, and the cuff or cylinder thus formed is dragged below the skin margin.
5. The mucous membrane above the hæmorrhoids is then divided transversely, thus removing the pile-bearing area, and the operation is completed by suturing

*Read before the Philadelphia County Medical Society, September 24th, 1890.

†British Medical Journal, February 6th, 1887.

the upper margin of the severed membrane to the free margin of the skin.

The advantages claimed by Whitehead for this method of treatment are based on pathological and on surgical reasons. He considers that the internal haemorrhoids, which are generally regarded as localized distinct tumors, amenable to individual treatment, are, as a matter of fact, component parts of a diseased condition of the entire plexus of veins surrounding the lower rectum, each venous radicle being similarly, if not equally affected by an initial cause, constitutional or mechanical.

The operation of excision is the only one which removes this whole diseased area. It is, therefore, demanded for this pathological reason. It is in addition surgically more perfect than any other method of treatment, because it provides for the readjustment of healthy tissues with the object of securing primary union and rapid convalescence. It does not leave the sluggish ulcer of the cautery, nor is it attended with the pain and slow convalescence of the ligature.

My experience with this operation is limited to ten selected cases. Only those cases were selected in which there existed a complete circle of haemorrhoidal tumors surrounding the lower margin of the rectum, since for such cases Whitehead's treatment of excision seems to be most particularly adapted.

The details of the operation are simple and easy to execute. In dividing the mucous membrane from the skin it is best to begin at the posterior margin of the anus in order to prevent the blood from obscuring the field of operation. No skin should be sacrificed, even though there appear to be redundant tags around the margin of the anus. The skin always retracts somewhat and the tags shrivel and disappear before firm union has taken place. Failure to observe this rule may result in subsequent serious trouble. Kelsey* reports the case of a woman who had been subjected to a so-called White-

head operation and who presented herself to him with a complete circle of excoriated mucous membrane, extending for one inch outside the anus. It is probable that in this case the operator had sacrificed too much skin.

On the other hand, the upper section of the mucous membrane should be made in the same horizontal plane throughout, in order to prevent subsequent ectropion ani.

The dissection of the mucous membrane from the underlying tissue is exceedingly easy except in some cases of old—or long standing—piles. The attachment of the submucous tissue is very loose, and separation can be effected with the finger or with the handle of the scalpel. It is not always possible to dissect the piles completely from the underlying structures, as they may involve not only the mucous but the submucous tissues, and in such cases it is necessary to cut partly through the piles until the healthy mucous membrane above is reached. Repeated attacks of inflammation of course render closer the adhesion of the pile area to the underlying structures. In one of my own cases, where the piles had existed for forty years, and had frequently been inflamed, the adhesions to the two sphincters were so close that a few muscular fibres were cut away during the removal.

The amount of blood lost during the operation is surprisingly small. Whitehead states that he has often operated on severe cases and not found it necessary to twist a single vessel. In five of my cases no haemostasis was necessary. Bleeding is avoided by adhering closely to the mucous membrane in the dissection, as the larger arterioles lie beneath the submucous tissue. The arterial bleeding occurs in those cases of old piles which have been subjected to previous operation or to attacks of inflammation, and in which dilatation of the rectal and anal arteries has taken place secondary to dilatation of the haemorrhoidal veins. The bleeding from the upper divided

**New York Medical Journal*, Oct. 5, 1889.

edge of the mucous membrane can be reduced to a minimum by following Whitehead's method of inserting the sutures as each portion is divided, or by adopting Marcy's plan of introducing a circle of shoemaker stitches of catgut around the mucous membrane above the piles before cutting the mass away.

Whitehead's advice is in all cases to remove the complete cylinder of mucous membrane, whether or not the whole of this area appears to be diseased. He gives this advice for the reason which I have already stated, that he considers the individual piles as but part of a general pathological condition, involving all the lower haemorrhoidal veins of the rectum.

Whether we accept this pathological view or not, it is best to follow this plan, and to make a complete circular division of the mucous membrane, as by this method the best surgical results are obtained, and ectropion ani prevented. I have seen a case in which only one-half of the circumference of the mucous membrane of the rectum was removed, and a few hours after the operation an edematous swelling formed in the other half, which has now resulted in a haemorrhoidal tumor almost as annoying as the one for which the operation was performed.

In attaching the mucous membrane to the skin, Whitehead uses the interrupted silk suture. He never removes the sutures, but allows them to ulcerate through—a process which is very easily accomplished. In my own cases I have used the continuous catgut suture.

The treatment of these cases after operation is very simple. It is rarely necessary to use opium or the catheter. An opium and belladonna suppository introduced immediately after the operation, is in most cases all that is required.

The bowels can be moved in from twenty-four hours to four days, and with very little pain. Absence of pain after Whitehead's operation is due to the thorough paralysis of the sphincters, and to the fact that no source of irritation is left beyond that of a clean linear inci-

tion, united without tension and without strangulation of tissue.

A glance at the histories of my own cases shows that they were all cases of aggravated haemorrhoids, in which the piles covered the whole circumference of the lower part of the rectum. In all the cases the disease had existed for many years, and two had been subjected to previous operation by the ligature.

In only one case was there anything like free bleeding during the operation.

In all cases a suppository of one-half grain of extract of opium and one-half grain of extract of belladonna was introduced immediately after the operation, and this was all the opium required except in three cases, in which one-sixth grain of morphine was subsequently administered.

The catheter was used in only three cases, and in these for a period not longer than twenty-four hours. The length of time that the case is confined to bed depends to a great degree upon the social standing and the disposition of the patient. In my cases it varied from two to ten days. Every case should be able to sit up in four or five days, and to resume work in ten days or two weeks.

The bowels were opened without pain in from twenty-four hours to four days after operation.

No complications of any kind followed these operations. Union takes place quickly, and generally one dressing, taken off when the bowels are moved, is all that is necessary. In no case was there incontinence from paralysis of the sphincters, or any tendency to stricture, from contraction of the scar.

Since the publication of Whitehead's paper his method of operating has been tested by many surgeons. The operation cannot be criticised on surgical grounds, as it is certainly the most perfect plan of treatment, surgically speaking, which has been proposed.

The immediate removal of the tumors, the coaptation of healthy tissues, and primary union, are substituted for slow

strangulation by the ligature, or removal by the cautery and healing by granulation.

The applicability, or the necessity, of this operation in all cases of haemorrhoids, is, however, open to criticism. If we accept Whitehead's views in regard to the pathology of piles, and believe that the whole venous plexus surrounding the anus and the lower end of the rectum, is in a pathological condition in every case of haemorrhoids, even though there may be present only one or two isolated tumors; then, of course, the complete removal of this area is indicated.

But, that this view is not true is proved by the thousands of cases which have been permanently cured by the ligature and the clamp. The method, however, is indicated in all cases of aggravated haemorrhoids where the vascular tumors cover the whole or the greater part of the circumference of the bowel. In such cases the operation presents no great difficulties. Statistics show that it is at least as safe as operation by the ligature or the clamp, and it is certainly followed by a more rapid convalescence, and much less pain and discomfort.

Society Reports.

PHILADELPHIA COUNTY MEDICAL SOCIETY.

STATED MEETING HELD SEPT. 24TH, 1890.

Dr. Joseph Price read a paper entitled

CERTAIN CAUSES OF MAJOR PELVIC TROUBLES, TRACEABLE TO MINOR GYNÆCOLOGY.

(See page 545.)

Dr. E. E. Montgomery said I fully second what Dr. Price has said with regard to the frequency of troubles necessi-

tating major operations which result from the various methods of procedure in minor gynæcology. I do not think that any person who has practised gynæcology has not met with cases of inflammatory trouble of the uterus travelling to the ovaries and to the peritoneum, giving rise to conditions which have been described as peri- and para-metritis, which have resulted from the use of the uterine sound. When we consider the fact that the uterine sound has been a part of the routine method of examination of many physicians practising this branch of the profession, it is not surprising that these troubles should so frequently occur. The uterine sound, as has been stated, should not be introduced in any case until the patient has been thoroughly examined and the presence or absence of any inflammatory condition in the uterus, or about it, has been eliminated.

The practice of Emmet's operation upon cases as soon as they consult a physician for treatment, where a slight laceration is found and the physician at once attributes the symptoms to this lesion and performs the operation, has justly led to its discredit. The operation is undoubtedly one which, in some cases, is of great benefit; it is, however, in properly selected cases. No case in which the presence of other inflammatory conditions has not been eliminated or cured by proper methods is suitable for the operation. One reason, I think, why Emmet's operation has proved so disastrous in many of these cases is the fact that, as the result of sub-involution of the mucous membrane from this lesion, we have an increased amount of secretion which, after narrowing of the cervical canal by the operation, is unable to escape freely; consequently, the uterus becomes dilated to a certain extent, and this favors more rapid extension into the Fallopian tubes and the development of serious trouble. One cause of the extension of inflammatory trouble from the uterus to surrounding parts is insufficient drainage from the cavity of this organ.

Then, again, Dr. Price very justly

condemns the use of irritating materials which have been employed in the cavity of the uterus. Many who have proposed agents for the treatment of inflammatory troubles in the cavity of the uterus have seemed to labor under the idea that the only method of curing these inflammatory lesions was by destroying the mucous membrane in which they originated. The application of nitric acid, chromic acid, nitrate of silver in stick, and the like, results in relief by destroying the mucous membrane from which the secretions take place. In this way inflammation may be caused which may extend to the deeper structures of the uterus and to the pelvis. I fully agree with all that the gentleman has said in regard to the importance of care in the treatment of these various classes of cases, to avoid adding to the discomfort and to the crippling of the whole future of the individual who applies for treatment.

Dr. John C. DaCosta said, I am glad to hear Dr. Price speak of the dangers of minor gynaecology, but I do not know how we shall get along without it, unless we adopt the rule (which he leads us to infer from his paper is his), that in all these ailments we open the abdomen and remove the tubes and ovaries. I hardly think that Dr. Price is right in attributing the major pelvic troubles to gynaecological treatment, for, from the little that he has said, I think that we may infer that the pelvic trouble already existed, and the practitioner made a mistake in treating the uterus rather than the uterine appendages. I am glad to hear him speak in regard to Emmet's operation. I have heard long lists of cases reported with the statement that "all recovered without bad symptoms." That has not been my fate. One of the hardest fights that I have had for a woman's life has been after an operation on the cervix. Many unnecessary operations are done on the cervix. They are often done by men who want to make a record—by men who practise gynaecology without knowing much about it. They see a torn cervix, and, without knowing whether or

not the symptoms are due to that, proceed to operate. They do it, also, without properly preparing the patient beforehand. Where a lacerated cervix needs operation, as a rule, it needs previous treatment. If the cervix is put in proper condition, there will not be the same liability to bad results.

There is probably no instrument that is more used in minor gynaecology than the dilator, and there is probably no instrument that can be more abused than the dilator. Professor Goodell has reported to this Society many cases in which forcible dilatation has been used with grand results. I have used forcible dilatation in many cases, and have never had any bad results. The reason is that, when I began the study of gynaecology, I was taught how to use it properly and and not to use it in every case. Take the sharply bent womb, and all the pessaries made will not straighten it. You must put something inside, either a dilator or a sponge tent. Again, let the uterus become congested and the mucous membrane swollen, closing the uterine canal and causing dysmenorrhœa. You can cure that case in from two to four treatments by dilatation, while you may treat it by other means for months without doing good. The dilator is a surgical instrument, and one which must be handled carefully. You must know how to do your work before you attempt to use it.

Now, in regard to the use of the sound. I hear gentlemen state that they can outline any uterus without the sound. I have tried that, but have never been able to do it. Take a uterus enlarged, like this sketch, and I defy anyone to say in what direction the canal runs. It may be a uterus in the normal position with a fibroid of the posterior wall, or it may be a retroflexed uterus with a fibroid on the anterior wall, or a plastic mass between the uterus and bladder. It behoves us to use the sound carefully. If a man tries to force the sound into the canal, he will certainly do damage. If, however, he will outline the shape of the

uterus as well as possible, and then bend the sound to fit as nearly as may be, and then make effort after effort, he can, in the most distorted uterus, get the sound in without damage.

Then, in regard to the curette. These usually have a sharp, cutting edge. Such an instrument is hardly safe for an able practitioner to use, and is not safe at all in the hands of an unskilled person. Where inflammation extends from the uterine cavity to the tubes, after the use of the curette, it is not so much from the instrument as from the man who uses it.

I should be loth to give up intra-uterine applications. I have used them a long time, and, while sometimes pain has been caused, they have never done any serious damage. As Professor Wallace used to say, "Some uteri are sensitive to the slightest touch, and some are as stupid as oxen." When you make an application, you must know the uterus which you are treating. Nitrate of silver used to be a common application, but it is one of the worst that you can make. It will, as a rule, produce cicatricial contraction of the canal. Nitric acid, although so much stronger than nitrate of silver, is not so apt to do this; but nitric acid is rarely required. In a case of fungous granulation, I should not hesitate to scrape out the whole inside of that uterus and make a strong application, and, after watching the patient for a short time, send her home, and not expect to have any trouble. This is because I know my cases. I do not do it to every case.

I think that Dr. Price will find that the dangers from minor gynaecological operations are more because of want of good sound judgement in the practitioner, and not so much in the operation itself. I cannot agree that pelvic troubles are always due to these minor operations.

Dr. Joseph Hoffman said, I have put on record in the Obstetrical Society a case where the uterus was perforated by the curette, and this case serves to show

that the remarks of Dr. Da Costa enforced the argument which Dr. Price endeavors to bring out, to wit, the danger from the wide-spread use of the uterine sound, the curette, and the dilator, as advocated by some. I believe that, if we took all the gynaecological instruments invented and put them together and multiplied them by ten, we should have no such instrument as gives such bad results as the dilator. It is easy for Dr. Da Costa to claim that he knows when to use it and when not to use it. I think that he overestimates his ability, to say whether he has ever done harm by it, for patients rarely come back after they are harmed. I have seen to-day two patients that had been treated by the curette, and from whom I have removed the appendages. In one case that I know of, the uterus was torn by the dilator, then a sponge-tent was put in and allowed to remain I do not know how long. You know the rest. In the case in which the uterus was perforated by the curette, the operation was done by a gynaecologist of considerable experience. Nevertheless, the uterus was ruptured and peritonitis was brought on and abdominal section was necessary to save life. I have to-day had two other women who were treated by minor gynaecology; they were both left very miserable. In one the vagina is much contracted and the pelvic viscera are certainly affected. In one of these cases, especially, electricity was used *ad nauseam*. The history is this: first, dilatation and scraping; then, closure of the perineum; and then, opening of the abdomen. In regard to operations on the cervix and perineum, we are to remember that operation on the perineum is not so apt to cause trouble as operation on the cervix.

What operations on the cervix are necessary? Every cervix with a slight laceration does not require operation. Some of these heal without suture, although traces of the damage may remain. The preparation of the patient often shows that operation is necessary — puncture and the ordinary derivative

procedures so reducing the size of the cervix that the laceration almost disappears.

In regard to ulceration of the cervix, I do not believe that there is such a thing, except as the result of bad laceration or specific disease. In laceration the ulceration is only apparent; it is really an erosion due to eversion and hypertrophy.

The curette in some cases seems to be a necessary evil which we cannot do without. I have found it useful in getting rid of putrid *débris* from a miscarrying uterus, in the early weeks of pregnancy, when the use of the finger is thoroughly clumsy and painful, if not impossible, without previous dilatation with a tent. In the presence of such detention, the use of the tent is not without danger, since, during the period of its presence in the cervical canal, all channel of escape for decomposing material is shut off. I can say that I have had no bad results, that I know of, in the use of the instrument.

As to the use of the sound, its use seems more confined to those who are wedded to the traditions of the instrument than from any *actual* value that can be attached to it. On the other hand, it is capable of doing much harm in the hands of those who need it most, because they know least about it and the parts with which it has to deal.

Dr. William E. Ashton said, the question of the use of the dilator depends upon one or two facts. First, as to the condition of the uterine appendages and their surroundings; and, secondly, properly selected cases. I do not imagine that anyone would use the dilator when we have present acute or chronic inflammation of the uterine appendages. I think that anyone who has had experience in the use of the uterine dilator would hesitate to employ it except in selected cases. I believe that where we have the pelvis perfectly free from local disease, and in cases where the uterus is strongly anteflexed and perfectly movable, and upon the introduction of the

sound we find that there is a point of intense pain at the internal os, we shall find in a certain proportion of cases that good results are obtained from the dilator. It is nonsense to talk about the causes of dysmenorrhœa. It is only a symptom. The vast majority of cases of dysmenorrhœa are cases which have a distinct tubal or ovarian origin. It would be absurd to rapidly dilate in such cases.

In regard to Emmet's operation, I quite agree with Dr. Price in reference to minor gynaecological operations dealing most disastrous results in the pelvis. We have to look only at the various clinics, and see the recklessness with which various operations are done, to see why we have so many abdominal sections. The reckless use of the sound and of uterine applications are responsible for many of these cases. I hold that the sound should only be used after a diagnosis is made. If the diagnosis is made, of what use then is the sound? In a case like that figured by Dr. Da Costa, I do not care what direction the uterine canal takes. If it is a fibroid, I do not see of what use such knowledge would be.

I cannot understand how any man can use instruments where there are inflammatory conditions around the pelvis, because they are a source of irritation and may light up acute inflammation in chronic cases. It should go on record that the uterine sound should only be used by men who have a thorough knowledge of the pathology of the pelvis, and who can appreciate the great danger incident to inflammatory troubles in the pelvis.

I agree with Dr. Price that there are few cases in which Emmet's operation is necessary. I grant that there are cases, in which the uterus is in a state of sub-involution, where a plastic operation will bring about the cure, but I do not believe in operating on the uterus if there is any diseased condition of the appendages. Any manipulation under such circumstances is apt to set up inflammation.

Four years ago, I had a case of bad laceration of the cervix in a woman, with pus tubes on both sides. I refused to operate on account of the disease of the appendages. She then went to New York, and was operated on by a prominent gynaecologist, and died of large abscess, the result of the operation lighting up the old inflammation.

Dr. Da Costa in answer to Dr. Ashton said, I probably did not make myself clearly understood. I do not want it understood that I would do an operation on the cervix if there was inflammation in the pelvis, such as pus tube or anything else. My teaching is: When there is violent inflammation in the pelvis, not to do any operation on the uterus, and to hesitate to use the sound. The discussion has run off from the original text, and it is for that reason that I make these additional remarks.

Dr. J. M. Baldy said, I think that there is no question in the minds of gynaecologists that Emmet's operation is a much abused operation. I think that it is also true that the vast majority of these ill-advised operations on the cervix are done by men who have no gynaecological experience and who know very little about gynaecology. I can recall two cases in which I was recently called to operate on the cervix by general practitioners, and by whom I was informed that the lacerations were very bad and that the women were suffering greatly. On examination, the tears proved to be comparatively slight, and needed no interference. There are some cases in which a cervix operation at first sight appears justifiable. These are cases in which the cervix is torn to the vaginal vault. I care not if the cervix be torn on both sides to the vaginal vault, if there is not eversion and erosion, or much scar-tissue, there is no reason for operation.

I should be loth to give up forcible dilatation in certain cases. It is not to be done in every case of dysmenorrhœa, for the vast majority of cases of dysmen-

orrhœa are due to ovarian or tubal disease. I believe that in the vast majority of cases where trouble follows the use of the dilator, there has been preexisting pelvic trouble. I do not think that a carefully done dilatation in a healthy pelvis will do harm. It is admitted that it does tear uterine tissue, but that this can cause trouble, unless the wound becomes septic, I am not prepared to admit.

The use of the sound in the hands of a doctor is in inverse proportion to his skill. The man who is skilled, rarely uses it. In such cases as have been mentioned by Dr. Da Costa, I see no use for the sound. I do not see anything essential that it could tell. I must say that I have not seen a uterus of the exact shape he has figured on the board. In the vast majority of cases I have been able to tell which was fundus and which was tumor. If we are dealing with a fibroid, it makes no difference what wall of the uterus it occupies. I do not suppose that I use the uterine sound once a month.

The curette, I think, is a valuable instrument, but it is abused and used indiscriminately. After abortion, I find it most valuable. In some cases of chronic endometrial disease it is valuable. I believe that it will remove almost all necessity for intra-uterine treatment. I find such applications rarely called for, except, perhaps, the application of nitric acid or iodine, after the use of the curette. I think that the dull curette is useless. The only rational instrument to use is the sharp curette. I was recently called some seventy miles to see a case where the physician assured me that the uterus contained nothing, as he had twice gone over it thoroughly with the dull curette. I used a sharp curette and removed large masses of placental tissue. The sharp curette can be used with as little danger as any other instrument, if used properly in skilled hands.

Dr. J. M. Fisher said, I am engaged in treating a number of uterine troubles

with electricity. Dr. Price has stated that the use of the electrode is fraught with much danger. That the introduction of any instrument into the uterine cavity carries with it a certain risk is not denied, but that the electrode is especially responsible for many of the diseases can certainly be questioned. There are certain diseases of the uterine tissue and lining membrane that can be most effectively treated by properly applied galvanism. I can cite one case in which the use of electricity saved the patient from undergoing a major pelvic operation. A woman, forty two years of age, had a fibroid uterus with haemorrhages, so that she was confined to bed half the days of the year. At the time I was called she had been laid up for nine weeks and was exsanguine from loss of blood. She had been treated by two good practitioners, and, failing to give her relief, operation was proposed and about to be done. I made a positive application of electricity, and, after the first or second application, the haemorrhage was arrested. Four applications, extending over a period of twenty-one days, were made. This was in November and December, 1889. After that she menstruated regularly until May, when she was again seized with haemorrhage. I was out of town, and the bleeding continued three weeks. On my return, I made a positive application of electricity, and since then the menstrual discharge has been regular, lasting three or four days.

Dr. C. P. Noble said, I am glad that this matter of the uterine sound has been brought up, because I am convinced, as the result of my experience, that the less the uterine sound is used, the better for the patient. In most cases but little information is gained. Recently a case passed through my hands in which the question of pregnancy was mooted. She afterwards fell into other hands, and the sound was passed three inches and the patient was supposed not to be pregnant. She was, however, seven months pregnant, as subsequent events showed. The

information given by the sound is often delusive. I, however, cannot see that the simple passage of the sound, provided it be clean and passed through a speculum, with a clean cervix, should set up pelvic inflammation, provided such trouble does not already exist. This, however, is neither here nor there, for I do not see that we need to use the sound in diagnosis. In small uteri it is not needed, because the organ can be outlined bimanually; while in large uteri, where tumors are present, the instrument may not reach the fundus, and so give incorrect information.

I must agree with Dr. Baldy, rather than with the author, in regard to rapid dilatation. I should be loth to give it ip. I have never seen harm follow rapid dilatation in any case. This is due to the fact that dilatation has been used in cases in which the disease is limited to the uterus. I agree that it is useless and dangerous to dilate the uterus when tubal disease is present. In uterine disease it is capable of doing a great deal of good. I am quite sure that a certain number of cases of tubal disease are set up by a narrow cervix. The secretions of the uterus cannot gain egress and set up endometritis, and the inflammation travels into the tubes. In these cases, if the cervical canal is dilated to allow the freer egress of secretions, it will be a positive factor in the prevention of tubal inflammation. In such cases as were mentioned by Dr. Ashton, of acute anteflexion, the dilator does a great deal of good.

In fact, in regard to all these minor measures which have been mentioned tonight, I find them of service, but the fact must be emphasized that they are useful only when the disease is limited to the uterus; and that the uteri should not be operated on in any way, in the presence of pelvic inflammation, particularly abscess.

Why we should give up the curette I cannot understand. There are more cases of haemorrhage from the uterus due

to uterine disease purely, where there is no ovarian or tubal disease. In such cases the use of the curette will permanently control the haemorrhage.

I think that one reason septic troubles follow minor operations is because anti-septic precautions are not observed. I think that is the case with the dilator. If used on the office-table, it is impossible to employ complete antisepsis. If such precautions are used, and there is no extra-uterine inflammation present, I do not think that inflammation will follow any of the minor gynaecological operations.

Dr. Price said, I am sorry that the discussion has taken the direction that it has, for it does not give me an opportunity to express myself thoroughly; it does not give me an opportunity of calling things by their right names. I have thrown down the gauntlet, and no one has quite taken it up. Some one has spoken of minor gynaecological methods. In a recent article a writer prefaces what he has to say by giving details of methods for the treatment of "ordinary gynaecological troubles." I do not know what "ordinary" gynaecological troubles are. If it means from 9 o'clock to 3 in an office, with a nurse and a Sim's speculum, peeping at cervices and taking ten dollars from each patient, then I understand it. He is the great mischief-doer. He tinkers, dilates, curettes, and passes the sound, and in from four to six weeks I get a telegram to come and open the abdomen to save the patient's life; that the woman is leaking; that she has a pulse of 130-140, with a temperature of 104°. This occurs weekly.

A speaker stated that there is no harm in electricity. Three fibroids in that jar have pus in them as the result of the use of electricity. Of the twenty specimens in that jar removed during August, fifty per cent. followed dilatation, closure of the cervix, the use of the sound and the curette. These specimens have come from four clinics in this city and from ten prominent gynaecologists. They all

had sections to save life, and all were greatly complicated operations.

In regard to the sound, Dr. Ashton has said all that I am capable of saying. I have not used the instrument for many years. It is a common method of determining the existence of pregnancy, particularly among homœopaths, although not confined to them.

In comparison with the former state of the same subject, we must inquire into the causes which must have been at work during the past few years. This private-office work has a great deal to do with it. Many of these men are simply cervix-feelers, and never find anything above it. There may be a mass larger than the uterus to one or both sides; which he fails to find. They are not anxious to find them, and would not be troubled by them.

The dysmenorrhœa in infantile uterus has nothing to do with the uterus. Pelvic pain in all infantile conditions of the uterus and pelvic viscera is exceedingly common. In these cases dilatation avails nothing. Dr. Baldy says that he uses the sound once a month. I presume that he dilates about once a month. I will consider together drainage of the uterus, referred to by Dr. Noble, and the use of the sound and dilator, referred to by Drs. Baldy and Noble. The sound measures about two lines in diameter, but we will say that it measures only one. I am sure that the drainage is quite sufficient through a canal one line or more in diameter. I find that those who have such a love for dilatation always precede it by the use of the sound. If they use it for drainage the indications are not clear.

Dr. Baldy said, I would ask to what part of my remarks Dr. Price refers. He has entirely misunderstood me. He stated that presumably I dilated for drainage, and that I first pass the sound, which will of itself establish drainage, without the dilator. My remarks were not in regard to dilatation for drainage or anything of the kind. I do not know

that I specified what I would dilate for. Time did not admit of my discussing that point. In regard to passing the sound once a month, I do not know that I meant to make that a positive statement. The statement was simply made to illustrate the infrequency with which I use the sound.

Dr. Price said, I thought that I had made that clear. I said that I would call attention to two points—that of drainage, as referred to by Dr. Noble, and the sound and dilator, as referred to by Dr. Baldy.

In regard to closure of the cervix, there are a few cases in which the operation is of importance, but the ordinary method of closing the vaginal surface of the cervix only is very imperfect. This forms a large cuspidor-like cavity or retention sac. I have repeatedly split these up, freshened the cervix, and made a perfect cure.

I have thrice this summer been called out of the city to open the abdomen in cases in which dilatation had been performed a short time previous.

Disease of the cavity of the uterus and fungous vegetations are far from common. Many healthy uteri are curetted, and it is thought that granulations are found. If the woman had been let alone, she probably would have conceived. The same is illustrated by a class of cases which I have studied among women locked up in a reformatory. Some twenty or thirty women, who had been living lives of chronic inebriety and lust for three or more years, had none of them conceived. After six months' rest iron, and good diet, the greater number conceived on leaving the institution. In these cases no intra-uterine treatment was employed, and only one examination was made to determine the position of the uterus, and its relation to surrounding parts in the pelvis.

As a diagnostic instrument, I do not see why anyone should want to use the sound. As a student, I never could see what was gained by the use of the sound;

in the hands of the trained or experienced it is not needed, and in the hands of the inexperienced it is dangerous. Too much prominence is placed upon an unhealthy condition of the cavity of the uterus; it does not often exist; it is exceptional.

Dr. Charles B. Penrose read a paper entitled

THE TREATMENT OF HÆMORRHOIDS BY EXCISION.

(See page 549.)

Dr. W. D. Green said, I have had the pleasure of witnessing only a small number of Whitehead's operations, but I fully agree, and I think that those who have tried the operation will fully agree with Dr. Penrose, that the method of excising through the whole circumference of the bowel, the pile-bearing mucous membrane and drawing down upon the upper segment and then attaching this to the lower segment without including the skin, has the advantage, first, of removing all possibility of return of the trouble; and, secondly, as Dr. Penrose has stated, in making a clear, clean, linear incision around the circumference of the bowel. Nearly all of us have seen the immense amount of suffering which the older operations by means of the clamp and ligatures, and even the cautery, have entailed. In the case of the new operation which I have seen, recovery has been rapid and complete. In one case, that of a woman well advanced in life, upon the day after operation, when I got to the house, I found her comfortably seated in a rocking-chair. The physician who had had the case in charge before the operation, had given her freely of some medicine to open the bowels, and on the morning after the operation, without any pain and without any tenesmus, she had a large, well-formed motion. In the old method, in which for days the physician was called upon to administer opium, either by sup-

pository or hypodermically, in large amounts, and in which the patient and the physician both looked forward with dread to the time—five, six, or ten days after the operation—when the bowels were to be opened, is by this method entirely obviated.

I have seen, in the few cases which I have watched, no pocketing or trouble about the line of incision. The two freshly cut surfaces unite very quickly—very much more so, it seems to me, than in mucous surfaces elsewhere. Even when the bowels were moved within twenty-four or thirty-six hours, I was surprised to find that there was no trouble.

It strikes me that the continued suture has advantages over the interrupted. Being introduced and made fast at one point, and then carried out and in around the circumference of the bowel, if catgut be used at the time when union usually occurs, the suture is probably dissolved and passes away without any trouble; or, if silk be used, by simply introducing the scissors and cutting close to the knot and giving an easy pull, the whole suture is removed without any pain or bleeding.

I must confess that the operation presents to me by far the best method of removing the pile-bearing membrane when it exists and involves one-half or more than one-half the membrane around the circumference of the bowel.

SUCCESSFUL REMOVAL OF A HYDATID CYST PRESSING ON THE MOTOR REGION.

In the *Australasian Medical Gazette*, July, 1890, Dr. Graham and Mr. Clubbe report an extremely interesting and important case of severe brain lesion successfully treated by operation. The case was that of a youth, aged 16 years, whose previous history showed no serious illness. At 10 years of age, however, he was unconscious for two days, apparently from cerebral laceration after a fall. At the beginning of the present year, his

memory gradually failed; and in addition to suffering from giddiness and sickness he gradually became blind in the left eye. Weakness in both legs next appeared, and right hemiplegia. On admission to the Prince Alfred Hospital under Dr. Graham, both discs showed postneuritic atrophy. He was treated with large doses of bromide and iodide of potash, and improved very much in motor power. However, he had a fit, after which the right hemiplegia was much worse, and stupor began. Exposure of the arm area in the left hemisphere by trephining was then performed by Mr. Clubbe, and a hydatid cyst removed, having been found to be simply pressing on the "motor" area. The wound was closed and healed by the first intention. There was some subsequent oozing of cerebro-spinal fluid, owing, perhaps, to the employment of a drainage tube, but the patient made an excellent recovery, and has now regained the lost power. Unfortunately, the operation was performed too late to prevent atrophy, and so the patient, it is to be feared, is permanently blind. In every respect, however, the case is a most valuable contribution to the literature both of cerebral surgery and of hydatid disease.—*British Medical Journal*.

Philadelphia prohibits the use of the phonograph for fear of infection from the ear pieces; but the public drinking cup still remains at the Park fountains.

The *Brooklyn Medical Journal* says: Dr. J. B. Mattison, of this city, is certainly entitled to have his name associated with the method which he has devised and perfected for the treatment of the opium habit. This method is distinct from either that of Erlenmeyer or of Levinstein, and is as original as either. In an exhaustive paper on "The Treatment of the Morphine Disease," contributed by the doctor to the September number of the *Therapeutic Gazette*, the details of his method are fully described. Those who are interested can obtain reprints on application to the author.

MARYLAND MEDICAL JOURNAL**Weekly Journal of Medicine and Surgery,****WILLIAM B. CANFIELD, A.M., M.D., Editor***Subscription \$3.00 per annum, payable in advance.*

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BALTIMORE, OCTOBER 25, 1890.

Editorial.**THE NEED OF AN AMBULANCE SYSTEM IN BALTIMORE.**

One of the daily papers of this city contained an article last week entitled "Jolting the Injured." Those who read that piece will see that Baltimore rather lags behind in providing facilities for the transportation of the sick. There is only one genuine, modern ambulance in the city and that the Johns Hopkins Hospital owns, and it is as unscratched as on the day it was bought, for it has never been in use. One or two other hospitals have ordinary express wagons, with the word "ambulance"

painted on the side of the wagon. To the police patrol, which is very efficient in some work, has been assigned the duty of transporting the injured and sick, and any one who has seen this "patrol-ambulance combination" on the street will wonder that so many injured people reach the hospital alive and do not die on the way. Again, the police, with all the light that their limited education affords them, do not know the difference between a "drunk" and any other form of unconsciousness, hence it not unfrequently happens that "supposed drunks" are allowed to die en route for the hospital or station house, when prompt relief from an intelligent hand would save a life; or the injured and sick are jolted to death before reaching their earthly destinations.

To be sure, the city streets of Baltimore are much against the smooth driving of carefully balanced ambulances, but there certainly could be an improvement on the present system of sick transportation. New York City is recognized the world over as having a model ambulance system, which Paris and other foreign cities are imitating with great satisfaction.

If our city officials can go to New York and elsewhere to study different methods of municipal government to get ideas as to improvement; if the postmaster can go about and examine into the postal facilities of other cities and countries, it does not seem extreme to suggest that a properly formed committee might visit New York and perhaps other cities and look carefully into the ambulance systems. The city maintains free beds in several hospitals, the foreign countries provide beds here for their sailors, certain socie-

ties endow free beds for sick members.

Taking all this into consideration, it does not look too Utopian to suggest that all, or at least the more prominent hospitals appoint representatives to meet the Mayor and several city councilmen, this committee to devise some ambulance system. The expense of this system could be borne in large part by the city and in part by each hospital represented in proportion to the number of beds used by the city. The ambulances could be kept at the station house stables, and a competent surgeon detailed from the hospital could be in readiness to go at any time with the ambulance. The city would be divided into districts and each hospital would be near enough to one ambulance to use it, and all would have their share of patients. In some such way, just roughly sketched, an ambulance service, limited, could be kept in operation at no great expense to the city or to the hospitals, and the comfort to our poor sick and injured, would be incalculable.

It would be very much in place if those interested in an ambulance system for this city would communicate their views to the JOURNAL. The agitation of this subject may lead to something better than the present state of affairs.

A NEW BUILDING FOR THE STATE SOCIETY.

Several years ago some members of the city profession tried to get together the necessary enthusiasm and money for a new building for the Medical and Surgical Faculty. This attempt failed, but the recent large addition to the membership last spring has suggested the old

idea to younger minds to start this project anew.

Our New York letter this week from Dr. Joseph T. Smith, of this city, gives a description of the new home of the New York Academy of Medicine. Of course, we cannot expect to rival New York, but we certainly should not be satisfied with our present gloomy and inaccessible accommodations, our musty halls and chilly rooms.

The profession has certainly increased in strength and wealth in the past twenty years, and many would be willing to contribute to it, not as a donation, but as an investment in a new building on a thoroughfare.

The holding of the presidential chair in the State Society is an honor and is not intended as a sinecure. We have a young, active and energetic president of the Faculty, and the profession expects great things from him for the Society.

The subject is an important one and requires more systematic pushing than heretofore, and a stronger appeal than these few words can give.

Correspondence.

NEW YORK LETTER.

NEW YORK, October 13, 1890.

Editor Maryland Medical Journal:

DEAR SIR:—We have seen many of the homes of the various medical societies in this country and abroad, but none of them is as neat, comfortable and attractive as the new home of the New York Academy of Medicine. If we, in Baltimore are ^{not} as well housed as we would like to be, and if our home is not

as bright and attractive as we could wish, it is a great pleasure to visit our neighbor and see the attractions of his new home. Thus it was, that having a few spare hours, I paid a visit to the home of the New York Academy of Medicine, 17, 19, and 21 West 43rd street, and was much impressed with the beauty and fitness of all I saw that I thought a word about the new building would not be amiss.

As you approach from Broadway the building stands out, a prominent and attractive object, much higher than the buildings on either side, within one door of the fine, new, cream-colored building of the Century Club. It commands your attention at once. It is built altogether of that reddish-brown stone which is used so much in the more modern buildings in the city. What would otherwise be a monotony of color and shape, is relieved by pillars between the windows in many places and by a curved balcony, the front of which is formed by a series of columns, and at either end, upon the top, rest two lions. The height of the structure is much relieved, from the fact that after reaching a certain height, the front wall breaks, and gradually narrowing on each side forms peaks, two in number. Walking along from the Broadway side you pass three handsome windows and reach the entrance way which is placed at the 5th Avenue end of the building, and occupies nearly if not just as much space as that occupied by the windows.

The entrance way is square, and the centre is supported by a large massive ornamental column; as you pass beneath the arch, on either side you find yourself in a large open vestibule, with a floor laid in mosaic stones; these stones in the centre form a circle, and within the circle the stone forms the symbol, well known to us all, of the twining snakes and the cup.

The door opens to the left and to the right is a large stained-glass window corresponding to the stained-glass in the

door. The door opens the way into a large hallway, flanked on the right by the janitor's room, the coat room, stairway, and passenger elevator; on the left by the reception rooms, the hallway to the smoking room and the main hall; the hall ends at the dining room. From the reception room, the large and comfortable smoking room is reached through a large doorway, at once, or you may follow the main hall, reach the smoking room by the narrow hall, without incommoding those in the reception room. The size of the smoking room shows that many of the New York physicians smoke, and its comfort, how much they will enjoy the luxury. A door from this room opens into the main hall.

The main hall is very capacious and very neatly ornamented; at one end is the platform with the ceiling over it arched and of ground glass, just opposite are the large doors which open at once into the dining hall.

The dining hall is a most delightful room for the purpose, with its curved ceiling of glass, its large mantel of white stone, its walls finished in ash, and its floor in hard-oil finish. Just back of this is the butler's pantry with stairs leading to the kitchen beneath.

The kitchen, with its dumb-waiter and hood-covered range, leads us to believe that the mental strain of the section rooms is to be relieved by the social pleasures of the banquet room.

We can reach the second floor either by the broad stairs of easy ascent, or the more comfortable elevator. Here we find a large hallway; just in front as we leave the elevator we find two doors, the one to the right opening into a narrow gallery, from which you look down upon the main hall; indeed it is part of the hall. The door to the left leads into a large room where the surgical section will meet to-night.

As you enter, a large bronze statue on an ebony table confronts you; at the base of the statue are the words "La Frayeur;" to the left is the platform with its chairs

and tables of ebony, the former upholstered in red leather; the President's chair is canopied, its centre ornamented with a bronze medallion head of the great medical chief, Hippocrates. This is a very handsome chair, and was the gift of Dr. Fordyce Barker. Over this chair a panel in the wall states that this was the gift of Abram DuBois, etc. The presiding officer's gavel is the bust of Hippocrates, and doubtless when that old chieftain demands order he is instantly obeyed. This room opens upon the small gallery. The next floor contains the library and librarian's room; the library has two rooms, one the reading room and the other devoted to alcoves for the books. The rest of the house is devoted chiefly to section rooms, which present a pleasing variety. Two sources of bodily refreshment have been provided; one in the basement already noted, the other at the top of the house. Here we find a portion of the roof flat, railed in with its floor of brick, where, upon warm and sultry nights the tired mind can be relieved by cool breezes, and the panorama of the city spreads out before it. Electric call-bells, wash-rooms and closets on almost every floor, the woodwork everywhere the same, polished ash, provision for brilliant lighting, and floors finished in hard oil, make a picture of comfort we shall not soon forget. The stairs are iron and stone; the tints of coloring upon the walls are very restful to the eyes after leaving the glare of the streets, yet bright enough to dissipate all sense of gloom. Everything in and about the house is cheerful and attractive, as if designed to banish care and darkness from the mind and heart of all who entered. All the rooms and the hall on the first floor can be thrown together, thus giving ample space for receptions and public gatherings.

We trust the time is not far distant when we, too, shall have a new home; that some one will find it in his heart to help us we have no doubt, but when we see such a new home as we have just left, it makes us anxious that the time should

not be so long delayed. To have a house of our own would add greatly to our efficiency as a State Faculty, but when we find that the great city of New York has only just now provided a home for her medical men, we can control our anxiety and try to hurry on our day of good things.

Yours sincerely,
JOSEPH T. SMITH, M. D.
Grand Hotel.

Miscellany.

CANNABIS INDICA IN GASTRIC DISORDERS.

A very useful contribution to our knowledge on the treatment of the various varieties of indigestion is published in the *Deutsche Medicinische Wochenschrift* of August 14th and 21st of this year, by Dr. G. Sée, who, as stated in our Paris correspondent's letter of last week, has dealt with the same topic before the Academy of Medicine. After a full discussion of the forms of indigestion that are recognized, and the use of cannabis indica in their treatment, Dr. Sée arrives at the following conclusions: 1. The most convenient form in which to employ the drug is the extract in doses of about three-quarters of a grain daily, divided into three portions. Above this dose the drug is apt to produce unpleasant effects. (The French extract is stronger than the English.) 2. The drug was chiefly tried on the non-organic affections of the stomach. These were divided into two groups. The first included cases in which the gastric juice was altered in composition, especially if there was an excess of hydrochloric acid. The second group consisted only of cases of gastro-intestinal neuroses, in which there was no change in the digestive juices. 3. All these affections—dyspepsias and neuroses—were characterised by five sets of symptoms, occurring in various proportions. (a) Pain, local or ra-

diating, arising spontaneously or after food. The variations in appetite belong to this group. (b) Atony of the stomach, with or without dilatation, is almost always present. Vomiting is more frequent in the neurotic cases. (c) Flatulence and eructation occur in most cases; in the neuroses, the gas consists chiefly of air which has been swallowed; gases formed by decomposition arise from lactic or acetic acid fermentation, and not from excess of hydrochloric acid. These gases are the cause of the painful symptom known as "heartburn." (d) The gastric digestion of flesh food and albuminoids is little affected when hydrochloric acid only is in excess, but it is deficient when too much lactic or acetic acid is present, and completely in abeyance when there is deficiency of acid. In the neurotic cases gastric digestion is normal. Constipation is the rule in most cases. (e) In this last group are placed the various symptoms—giddiness, migraine, palpitation, agoraphobia, &c. 4. Cannabis indica gives relief from pain and increases the appetite in all cases, no matter on what causes the pain and loss of appetite may depend. If, however, too much hydrochloric acid be excreted, it is better to aid the action of the drug by large doses of bicarbonate of soda, given about four hours after food. Cannabis indica has no beneficial action on the atonic state of the stomach, but it relieves vomiting and cramp of the stomach. The drug has no direct influence in checking flatulence, but it aids the expulsion of the gas and diminishes heartburn. The digestion of food is improved, if the failure depends upon neuro-paralytic conditions, or is rendered painful by an excess of acid, but no improvement is produced if the disorder is caused by a want of acid. As regards the other symptoms—giddiness, sleeplessness, palpitation, and the like,—some relief is generally experienced by the use of this drug, but no alteration for the better is noticed in the hypochondriacal, hysterical, or neurasthenic con-

ditions. In short, cannabis indica may be said to be a true sedative to the stomach, without causing any of the inconveniences experienced after the administration of opium, chloral, or the bromides. It should be combined with the use of alkalies in large doses and with mild aperients.—*Lancet*.

Medical Items.

Dr. S. B. Bond was married recently.

Dr. Frank Chisolm, who has been ill with typhoid fever, is much better.

Dr. A. Lee Porter of Barton, Md., was married in this city last Tuesday.

Dr. Alexander Boggs, a well known English practitioner of Paris, died in that city recently.

Drs. H. Toulmin and J. M. T. Finney of the Johns Hopkins Hospital have opened an office at 923 North Charles Street.

The *British Medical Journal* publishes each week with its regular number, a supplement which contains a weekly epitome of current medical literature.

The dentists of Maryland object to being classed with manufacturers by the Census bureau, and have protested at Washington.

The sick horses of the city are taken to the hospital in a handsome covered ambulance, while the unfortunate human beings lie in uncovered patrol wagons.

Dr. A. H. Mann Jr., of this city, continued so unwell, that he returned to this city from Europe. He was accom-

panied by Dr. J. G. Van Marter Jr., who immediately went back to Europe.

The Medical and Chirurgical Faculty will hold its semi-annual meeting at Cambridge, Md., November 11th and 12th, 1890.

The daily papers state that Dr. James A. Steuart, formerly Health Commissioner, has gone to Westchester Co., New York, to practise.

Dr. E. M. Hartwell, of the Johns Hopkins University, has returned to the city from Europe, where he has been collecting material for lectures on physical culture, to be delivered in Boston, and at the Peabody Institute in this city this winter.

The following interesting advertisement is copied from one of last Wednesday's papers.

"I wish to buy a diploma from some recognized medical college, or school of medicine, which will entitle me to practise the care and cure of the sick. I am expert at dentistry and have lectured upon the subject of human health for years, and I can show proofs of having performed cures, that in certain hospitals had been given up. I wish to travel in other states than that of —— where diplomas are necessary in order to practise, and I will pay liberally for such a document. I will also answer with respect, all questions as to my fitness and ability, that may be sent me by officers of such school or college. Address:

— — —
Dr. William Murrell, of London, is naturally very indignant that Wm. Wood and Co., of New York, has published his work on chronic bronchitis without his knowledge or authority, and this in the face of the fact that P. Blakiston, Son and Co., most reputable gentlemen, have published an authorized American edition. On referring to the list of authors in Wood's monographs and com-

municating with these authors, Dr. Murrell finds that these works have been printed in Wood's Monographs without their knowledge or authority, and Dr. Richardson's work was published in the face of his protest. If Dr. Murrell's statements are correct, and there is every reason to believe that they are until Wm. Wood and Co. have proved the contrary, this is certainly a very discourteous and disgraceful piece of literary piracy, even though the absence of an international copyright does protect them. It shows, too, how much such a law is needed. There is one physician in Baltimore who will buy no American publication of English books, if the English book can be procured. Such a course is certainly honest. The question arises, are not those who buy pirated books doing wrong?

The Southern Homœopathic College, of this city, has elected the following faculty: Dr. Elias C. Price, institutes of medicine; Dr. N. W. Kneass, gynaecology; Dr. C. H. Thomas, clinical medicine and physical diagnosis; Dr. John Hood, hygiene and sanitary science; Dr. Eldridge C. Price, materia medica and therapeutics; Dr. Robert W. Mifflin, pathology and the practice of medicine; Dr. O. Edward Janney, paedology and orthopædic surgery; Dr. Henry F. Garey, ophthalmology and otology; Dr. Henry Chandler, physiology and neurology; Dr. E. H. Condon, anatomy; Dr. F. C. Drane, obstetrics; Dr. C. Wesley Roberts, Washington, D. C., pharmacy; Ex-Judge Henry F. Garey, lecturer on medical jurisprudence. The chairs of principles and practice of surgery and of operative and clinical surgery will be filled at a future meeting of the board. Dr. F. C. Drane was chosen dean of the faculty, and Dr. Henry Chandler registrar. The college will be conducted according to the principles advocated by the American Institute of Homœopathy, and in common with all other Homœopathic colleges in the United States, viz: a preliminary examination and a graded course of three years will be required.

